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IN THE

Supreme Court of the United States

OCTOBER TERM, 1997

RICHARD GILMORE, M.D. and PRATAP SARAF, M.D.,
Petitioners,

v.

DONNA E. SHALALA, Secretary of the United States Department of Health and Human Services

and

S. KIMBERLY BELSHE, Director of the California Department of Health Services,
Respondents.

Petition for Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

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PETITION FOR WRIT OF CERTIORARI

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QUESTIONS PRESENTED

1. Whether, in light of conflicting directions emanating from two lines of decision by this Court, courts must defer to retroactive legislation purporting to clarify the intent of an earlier Congress, even though the circumstances of the later enactment indicate that Congress was not interpreting prior law, the affected statutes were enacted eleven years earlier, and the appellate courts, prior to the later enactment, had unanimously interpreted the affected statutes to the contrary.

2. Whether Congress, consistent with Article III of the Constitution, may apply a new statute to direct the outcome of litigation to which the United States is a party in order to benefit the federal government, where the statute has no other retroactive effect.

3. Whether the retroactive application of a new statute, resulting in a reduction of the statutory rate of payment to health care providers for services already provided to certain federal beneficiaries, impairs vested property rights protected by the Due Process Clause and the Takings Clause of the Fifth Amendment and, when applied by the States, the Contract Clause of Article I.

4. Whether, prior to passage of the Balanced Budget Act of 1997, federal law permitted the States to limit "Medicare cost sharing" payments on behalf of "Qualified Medicare Beneficiaries"?

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OPINIONS BELOW

The opinion of the court of appeals is reported at *Beverly Community Hosp. Ass'n v. Belshe,* 132 F.3d 1259 (CA9 1997) and is reprinted in the Appendix hereto. The opinion of the district court granting summary judgment in favor of the petitioner is not reported and is also reprinted in the Appendix.

JURISDICTION

The judgment of the court of appeals was entered on December 2, 1997. A timely Motion for Rehearing With Suggestion for Rehearing *En Banc* was denied on March

3, 1998, and this Petition for Certiorari was timely filed. This Court's jurisdiction is invoked under 28 U.S.C. § 1254(1).

STATUTES INVOLVED

This case concerns the interpretation of 42 U.S.C. §§ 1396a(a), 1396a(n), and 1396d(p), and the related provisions of 42 U.S.C. §§ 1395*l*(a)(1), 1395u(h)(1), 1395w-4, 1396b(b), and 1396c, all of which are set forth in the Appendix. This case also concerns issues arising under Article I, § 10, Article III, § 1, and Amendment V of the United States Constitution, which provisions are set forth in the Appendix.

STATEMENT OF THE CASE

Petitioners are medical doctors who practice in California. They provide medical services to low-income persons, including some who are entitled to coverage under Part B of the federal Medicare program.

The Petitioners (the "Physicians") filed this action in 1996 in the United States District Court for the Central District of California against Respondents, the director of California's Department of Health Services and the federal Secretary of Health and Human Services (the "Secretary"). The Physicians alleged that the California Medicaid program ("Medi-Cal"), with encouragement from the United States, had illegally refused to pay them the 20 percent coinsurance and other "cost-sharing" that federal law required that the states pay on behalf of low-income patients enrolled in Medicare Part B and known as "qualified Medicare beneficiaries" ("QMBs"). The district court entered judgment for the Physicians in December, 1996, and issued an appropriate injunction.[1]

While an appeal was pending in the Ninth Circuit, Congress passed the Balanced Budget Act of 1997 ("BBA")

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[1] Petitioners filed this case as a class action, but no class was certified after Respondents agreed that they would honor the result for all persons providing services to QMBs in California.

which contained a provision (§ 4714) purporting to "clarify" the Medicaid Act to eliminate prospectively any right of medical providers to payment of the 20 percent cost-sharing for QMBs. Section 4714 also applied retroactively to any pending litigation.

The Ninth Circuit reversed, relying on the BBA, though it noted that all four federal appellate courts to rule on the issue before passage of the BBA had found prior law to require the contrary result.

A. QMBs and Medicare Cost-Sharing

This case involves the construction of federal statutes which, Physicians contend, required the states to pay Medicare copayments, known as "cost-sharing," on behalf of Qualified Medicare Beneficiaries, the QMBs, before the 1997 amendment. The case also involves construction of the 1997 "clarifying" enactment and evaluation of whether its retroactive aspect is unconstitutional.

Some background is necessary on QMBs and the law governing payment for their care. All QMBs are eligible for coverage under both parts of Medicare, the federal health insurance program for the elderly and disabled. Part A of Medicare automatically covers hospital and other institutional care for most Social Security beneficiaries. *See* 42 U.S.C. §§ 426(a), 1395c to 1395i-4. Medicare Part B, a supplemental program, requires that an eligible person enroll and pay a premium (much like a commercial insurance plan). *See id.* §§ 1395o-1395s. Part B covers services of physicians and other health professionals, as well as those of ambulance, home care, and medical equipment suppliers. *Id.* §§ 1395j-1395w-4j.

Medicare Part B pays 80 percent of the "reasonable charge" for most covered services. The beneficiary is responsible, in the ordinary case, for paying 20 percent of the charge—the "cost sharing" or coinsurance. *Id.* § 1395*l* (App. 25a); 42 C.F.R. §§ 424.55, 400.202 (App. 32a);

See also Your Medicare Handbook 1997 at 18-21 (App. 43a-49a). The "reasonable charge" for physician services is based on an annual fee schedule set by the Secretary. 42 U.S.C. § 1395w-4 (App. 26a).

Medicaid, the other relevant program, pays for medical assistance for the poor of any age. The federal and participating state governments (all 50, during the relevant time) jointly fund and administer Medicaid. *See id.* §§ 1396b, 1396d(b) (App. 28a, 29a).

Each participating state enters into an agreement with the Secretary and must implement a "State Plan" which meets federal requirements as to, among other things, the individuals and services to be covered and the amount that physicians and other providers will be paid for services. *Id.* §§ 1396a, 1396b (App. 27a, 28a); *Harris v. McRae*, 448 U.S. 297, 301 (1980). Most states adopt a fee schedule or otherwise set rates for the amounts to be paid physicians and other providers. *See* 42 U.S.C. § 1396a(a)(30). The federal government oversees the states' administration of the program and compliance with federal law, *id.* § 1396c, and reimburses each state for at least one-half of the costs it incurs. *See id.* §§ 1396b, 1396d(b) (App. 28a, 29a).

The first statute at issue requires that an approved state Medicaid plan cover the Medicare "cost sharing" of QMBs, their coinsurance and other copayment items. *See* id. § 1396a(a)(10)(E) (App. 27a). The QMB population includes two categories of low-income elderly and disabled: (1) a group of Medicare beneficiaries who are poor enough to qualify for full Medicaid benefits ("dual eligibles"), and (2) a second group, also Medicare beneficiaries, whose income is too high for Medicaid but otherwise falls below a statutory low-income standard ("pure QMBs"). *See id.* § 1396d(p)(1); *Pennsylvania Medical Soc'y v. Snider*, 29 F.3d 886, 889 (CA3 1994). The

second population, the so-called pure QMBs, is not eligible for Medicaid, though Medicaid is designated by statute to cover Medicare cost-sharing. *See* 42 U.S.C. § 1396a(10)(E)(VIII); App. 27a. Enacted in 1986, the statute has made state coverage of cost-sharing for both categories of QMBs mandatory since an amendment in 1988. *See* Pub. L. No. 100-360, § 301(a)(1), 102 Stat. 683, 748 (1988).

The second key statute sets out the elements of Medicare "cost-sharing" of QMBs to be covered under a state Medicaid plan, including, as relevant here: (i) Medicare Part B premiums; (ii) annual deductibles for Part B; and (iii) coinsurance under Part B. 42 U.S.C. § 1396d(p)(3); App. 30a-31a. States are required to cover these costs regardless of whether the same services would be covered under the state's Medicaid plan. *Id.*, § 1396d(p).[2] The meaning of this statute is undisputed.

Congress enacted a third statute in 1986, 42 U.S.C. § 1396a(n). Prior to its amendment in 1997 as part of the BBA, Section 1396a(n) stated that a state "may" exceed its Medicaid rates in paying Medicare cost-sharing amounts on behalf of QMBs. *See id.* (West 1997 Supp.); App. 27a. The dispute here arose from the Secretary's attempt to use § 1396a(n) to limit §§ 1396a(a)(10)(E) and 1396d(p)(3).

After enactment of the three statutes, the Secretary permitted states to limit—and, in almost all cases, to fail to

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[2] The statutory specification of the obligation to cover Part B coinsurance is stated in terms of a specific formula. The costs to be covered are defined as "[t]he difference between the amount that is paid under section 1395*l*(a) of this title and the amount that would be paid under such section if any reference to '80 percent' therein were deemed a reference to '100 percent'." 42 U.S.C. § 1396d(p)(3)(D). Section 1395*l*(a) of the Medicare Act states, with respect to physician services covered by Part B, that Medicare will pay 80 percent of the Medicare-approved fee schedule amount.

pay—Medicare cost-sharing payments for QMBs. The federal government eventually took the position that states were not required to pay the 20 percent Part B coinsurance on behalf of QMBs to the extent that the amount paid by Medicare (i.e., 80 percent of the Medicare rate) exceeded the amount that the state Medicaid program would pay for the same service. California adopted the policy by statute. *See* Calif. Welfare and Instit. Code § 14109.5.

The policy allowed California, and many other states, to avoid virtually all payment of Medicare cost-sharing for services to QMBs. In almost all cases, California's Medicaid payment rates are lower than the 80 percent federal share of a Medicare Part B payment. Under the policy, physicians and suppliers in California usually received nothing for part B coinsurance on behalf of QMBs and were paid only 80 percent of the Medicare rate for services provided to these Medicare beneficiaries.

The Secretary concurred in and approved California's non-payment of the QMBs' coinsurance.

B. Prior Litigation

Physicians and suppliers in other states that had adopted the same limitation on payment of QMB cost-sharing sued the Secretary and applicable state officials and prevailed in all four cases to reach the courts of appeals. In each instance, the court of appeals held that 42 U.S.C. §§ 1396a(a)(10)(E) and 1396d(p)(3) clearly required states to pay the full 20 percent Medicare coinsurance on behalf of QMBs and that the Secretary lacked authority to permit the states to cap those payments at a Medicaid fee schedule amount. *See New York City Health and Hosps. Corp. v. Perales,* 954 F.2d 854, 858-63 (CA2 1992); *Pennsylvania Medical Soc'y v. Snider,* 29 F.3d 886, 892-97 (CA3 1994); *Haynes Ambulance Service v. Alabama,* 36 F.3d 1074, 1076-77 (CA11 1994)

Rehabilitation Ass'n of Virginia v. Kozlowski, 42 F.3d 1444, 1450-60 (CA4 1994) ("the four Circuits").

The Secretary argued in those cases that 42 U.S.C. § 1396a(n), by implication, authorized the states to pay less than the Medicare rates for services to QMBs. In particular, the Secretary contended that because the statute provided that the States "may" pay more than their standard Medicaid rates on behalf of QMBs, they also "may" choose not to pay more than those rates. The Secretary asserted that this regulatory interpretation was entitled to deference under *Chevron, U.S.A. Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837 (1984). *See e.g., Kozlowski*, 42 F.2d at 1450; *Snider*, 29 F.3d at 902-03; *Perales*, 954 F.2d at 858, 861-62.

The four Circuits each concluded, however, that the intent of §§ 1396a(a)(10)(E) and 1396d(p)(3) was clear and contradicted the Secretary's interpretation, and that *Chevron* deference was inappropriate. *See Perales*, 954 F.2d at 858-62; *Snider*, 29 F.3d at 892-97, 902-03; *Kozlowski*, 42 F.3d at 1450-60; *Haynes*, 36 F.3d at 1076-77 (adopting and expanding upon the *Snider* analysis).

Three of the four Circuits concluded that 42 U.S.C. § 1396a(n) was better understood as an exception to the Medicaid Act's requirements in 42 U.S.C. §§ 1396b(a)(1) and 1396a that states not exceed payment schedules or methods otherwise approved in a State Plan. *See Haynes*, 36 F.3d at 1076-77 (incorporating *Snider*'s reasoning); *Snider*, 29 F.3d at 894-96; *Perales*, 954 F.2d at 859-60. This view recognized that when states pay the Part B coinsurance on behalf of QMBs, providers receive 100 percent of the Medicare-approved rate—which in most cases is more than the Medicaid rate for the same service. But for § 1396a(n), such payments would violate the Medicaid State Plan requirements. *See id.*

C. Trial Court Proceedings

The district court granted summary judgment for the Physicians and entered a declaratory judgment that California's QMB payment limitation, approved by the Secretary, violated the Medicare and Medicaid Acts, "including but not limited to 42 U.S.C. § 1396a(a)(10)(E)." App. 28a. The court also held that the policy violated plaintiffs' rights under 42 U.S.C. § 1983 to the extent that it denied full payment of Medicare cost-sharing on behalf of QMBs. App. 21a. The court enjoined the Respondents from approving, allowing to be implemented, and enforcing the challenged policy to the extent that it violates federal law by preventing plaintiffs from receiving full compensation for services provided to QMBs. *Id.*

The Respondents appealed the district court's judgment to the United States Court of Appeals for the Ninth Circuit.

D. The Balanced Budget Act of 1997

While the appeal was pending, the President signed the Balanced Budget Act of 1997 ("BBA"), Pub. L. 105-33, 111 Stat. 251, in August of last year. Section 4714(a) of the BBA amended 42 U.S.C. § 1396a(n) by adding new provisions which expressly authorize the states to limit Medicare cost-sharing payments for QMBs based on Medicaid rate schedules and, further, prohibiting physicians and suppliers from billing individual QMBs to the extent that a state does not pay the full Medicare cost-sharing amount. *See* App. 33a-35a. Section 4714(a) also added a "savings" provision to Section 1396a(n) preserving the rights of physicians and suppliers to collect cost-sharing amounts in such cases from commercial insurers in the event an individual QMB might be able to afford a private Medicare supplemental insurance policy. App. 34a.

The caption to Section 4714(a) ("Clarification Regarding State Liability for Medicare Cost-Sharing") and the accompanying Conference Report indicate that Congress purported to enact a "clarification" of Section 1396a(n)'s prior language that the four Circuits had interpreted to the contrary. *See* H. Conf. Rep. 105-217, 105th Cong., 1st Sess. (July 30, 1997) at 870-71; App. 35a, 38a.

The BBA made the amendments in Section 4714 effective prospectively, to QMB cost-sharing payments made on and after the date of enactment (August 5, 1997), and retrospectively, to a state's payment for "items and services furnished before" enactment "if such payment is the subject of a law suit that is based on" 42 U.S.C. §§ 1396a(n) and 1396d(p) and "is pending as of, or is initiated after, the date of enactment of this Act." App. 35a (BBA, § 4714(c)). The BBA thereby made Section 4714 applicable to payment for services already provided if payment for those services had been or would be sought through the courts.

E. The Court of Appeals' Decision

The Ninth Circuit reversed, accepting jurisdiction under 28 U.S.C. § 1291. App. 5a. The court of appeals held that the "clarification" in Section 4714 of the BBA must be given "great weight" under *Loving v. United States,* 517 U.S. 748, 116 S.Ct. 1737, 1749 (1996), and *Red Lion Broadcasting Co. v. FCC,* 395 U.S. 367, 381-82 and n.8 (1969) and by itself defeated Petitioners' claims. App. 12a-15a; 132 F.3d at 1265-67.

The court acknowledged that the four Circuits had "uniformly rejected [the] Secretary's reading" of the applicable statutes. *See* App. 14a; 132 F.3d at 1266. The court of appeals found a "split of authority" in what it described as the differing explanations of the former language of Section 1396a(n) by the four Circuits and several district courts, however, and concluded that the

changes the BBA made in the statute simply clarified it. App. 7a-8a, 14a-15a; 132 F.3d at 1263 n.4, 1266. The court described the Medicare and Medicaid acts as "baffling," and the 1997 amendments as "worthy of real deference" given that courts had had "extraordinary difficulty" in "divining the intent of the original Congress" that enacted Section 1396a(n). App. 14a-15a; 132 F.3d at 1266. The Ninth Circuit concluded it should "honor Congress' 'clarification' label and accept . . . § 4714's provisions as a statement of what Section 1396a(n) has meant all along." App. 15a; 132 F.3d at 1266.

The court of appeals did not analyze the meaning of the applicable statutes as they existed before the BBA, other than to add that it had "carefully explored the litigants' arguments" on that topic and on the constitutional issues the Physicians had raised. App. 15a-16a; 132 F.3d at 1266-67. The court held that its finding that Section 4714 was a clarification of prior law mooted the Physicians' claims of violations of substantive due process, the Contract Clause and the separation of powers. The court of appeals held that the constitutional arguments rested entirely on the premise that Section 4714 of the BBA was retroactive, rather than a "declaratory clarification of" of prior law. *Id.*

The court of appeals also found no Article III objection to the retroactive application of the 1997 amendments on the ground that Petitioners' case was "pending" on appeal at the time of enactment and the BBA amendments reflected a congressional intent to resolve all pending disputes. App. 10a-12a; *id.* at 1264-65. Applying its decision in *Gray v. First Winthrop Corp.*, 989 F.2d 1564 (CA9 1993), the Ninth Circuit stated that "[b]ecause Congress thus has such authority to *change* the law as to pending cases, its power to *clarify* the law—to confirm what the law has always meant—follows a fortiori." App. 12a; *id.* at 1265 (emphasis in original).

SUMMARY

The tension between decisions of four courts of appeal and a contrary congressional "clarification" with retrospective application which deprives citizens of vested property rights in order to gain budgetary savings focuses the significance of this case. In light of confusion among this Court's prior decisions on the weight to be given to Congress' reinterpretation of existing statutes and on relevant Separation of Powers doctrine, the issues here provide several bases for a grant of certiorari.

Four courts of appeals determined that federal statutes prior to August, 1997 required that physicians and other suppliers be paid full Medicare rates for services to QMBs. Congress amended the law in 1997, purporting to clarify it and retroactively to eliminate the right to full Medicare payment for past services as to which a lawsuit had been filed. Two later appellate decisions, including the court of appeals below, followed the congressional interpretation.

Certiorari should be granted to clarify this Court's prior instructions on the extent to which courts should defer to a later Congress' interpretation of an earlier statute (here, the provisions for payment in the QMB statutes). One line of cases, which includes *Loving v. United States*, 116 S.Ct. at 1749, states that subsequent legislation declaring the intent of an earlier statute is entitled to "great weight" in statutory construction. Another line of cases, represented by *United States v. Philadelphia National Bank*, 374 U.S. 321, 348-49 (1963), instructs that, "The views of a subsequent Congress form a hazardous basis for inferring the intent of an earlier one." The appellate courts are "in a quandary" over the conflict and "would welcome clarification by the Supreme Court." *See Paramount Health Systems, Inc. v. Wright*, 138 F.3d 706, 711 (CA7 1998).

Equally important, the Court should also grant certiorari to untangle the meaning of *United States v. Klein*,

13 Wall (80 U.S.) 128 (1872), and its impact on the selective retroactivity of an enactment such as the 1997 "clarification" in the Balanced Budget Act here. Whether *Klein* requires that retroactive legislation, which affects only pending lawsuits and effectively directs the outcome in favor of the federal government as a party to them, must be invalidated as a usurpation of the Article III role of the judiciary in interpreting a statute is a recurring and unresolved issue. The purported clarification also raises serious constitutional questions about Congress' (and the states') ability to impair vested contract rights having extinguished a statutory right to payment for services already rendered.

Further, this Court should resolve the conflict that now exists in the courts of appeal concerning the proper interpretation of the original, pre-1997 QMB payment statute —a conflict that exists solely as a consequence of the congressional enactment, eleven years later, of the new statute purporting to "clarify" the intent of the original enacting Congress.

The actions of Congress at issue undermine the integrity of federal health care and procurement programs. The Physicians acknowledge that Congress may change the law, and in so doing change the prospective expectations of those who contract with the federal government. The court of appeals in this case, however, has ceded to Congress the authority to reinterpret the rules that applied to transactions entered into years ago in order to change the terms of contracts for services already performed.

This degree of deference inappropriately elevates one line of the Court's decisions over another, the *Philadelphia National Bank* line, and permits the United States to trample concepts of the constitutional balance of powers, substantive due process, non-impairment of contracts, and just compensation in the interest of budgetary convenience.

The net effect of Congress' action makes the government a particularly "[un]reliable contracting partner," contrary to this Court's admonition in *United States v. Winstar Corp.*, 518 U.S. 839, 116 S.Ct. 2432, 2459 (1996), that the United States lacks power to repudiate its own debts simply to save money. *See id.*, 116 S.Ct. at 2459-60 & n.28, 2464-65 & n.39, 2468-69 n.51 (plurality opinion) *id.* at 2473, 2475-76 (Breyer, J., concurring); *id.* at 2478-79 (Scalia, J., concurring).

REASONS FOR GRANTING THE PETITION

I. THE DECISION BELOW AND A RECENT DECISION OF THE SEVENTH CIRCUIT COURT OF APPEALS HIGHLIGHT THE NEED TO RESOLVE THE CONFLICTING STANDARDS FOR JUDICIAL DEFERENCE TO STATUTORY INTERPRETATIONS BY THE LEGISLATIVE BRANCH.

A. The Purported "Clarification" of 42 U.S.C. § 1396a(n) in the Balanced Budget Act of 1997 Unconstitutionally Displaced the Circuit Courts' Unanimous Interpretation of Prior Law and Created Conflict in the Circuits.

Section 4714 of the Balanced Budget Act of 1997 purports, retroactively, to "clarify" a law that four circuit courts of appeals had found to have a clear meaning to the contrary. The Second, Third, Fourth, and Eleventh Circuits had unanimously rejected the Secretary's interpretation of the pre-1997 law and held that the plaintiffs, all situated identically to the Physicians, were entitled to full payment for services rendered to QMBs at the statutorily-defined Medicare rates. Through Section 4714, Congress plainly acted to deprive the Physicians and similarly-situated litigants of an objective judicial interpretation of their statutory rights. The statutes at issue are complex, but as the Second Circuit recognized:

> [C]omplexity is not the same as ambiguity. Congress passes legislation with specific purposes in mind.

> When the ordinary tools of statutory construction permit us to do so, we must attempt to discover those purposes from the text, structure, history of the acts in question.

Perales, 954 F.2d at 862-63.

The four Circuits ascertained the purposes of the original 1986 statute from its text, structure, and history. All four courts found a plain meaning interpretation of the statute sufficient to make inapplicable any deference to the Secretary's contrary interpretation. *See Snider*, 29 F.3d at 902 ("Our analysis reflects that although interpreting the relevant statutory provisions is not a simple task, there is in fact no ambiguity as to how much states have to pay. . . . Accordingly, *Chevron* has no application"); *Perales*, 954 F.2d at 862-3 ("[W]here we confront a statute that evinces a legislative purpose clearly at odds with the proffered administrative interpretation, we should not defer"); *Kozlowski*, 42 F.3d at 1459 ("[T]here can be no doubt but that the QMB is a Medicare enrollee, and that payment on her behalf must be made at the Medicare rate"); *Haynes*, 36 F.3d at 1076 ("the statute unambiguously requires the state to pay the full amounts specified. . . .").

The Ninth Circuit below and, more reluctantly, the Seventh Circuit a few months later, concluded, however, that the four Circuits' statutory analysis must give way to the intervening clarification of Congress. The two courts principally relied on a line of this Court's decisions represented by *Loving v. United States* for the proposition that the enactment of a subsequent Congress is to be given "great weight" in interpreting prior law. *See Beverly Comm. Hosp.*, 132 F.2d at 1265-66 (App. 12a-13a); *Paramount*, 138 F.2d at 710-11. The court of appeals deferred to Section 4714 without even analyzing the prior law. App. 10a, 14a-16a; 132 F.3d at 1264, 1266-67.

But the *Loving* line of analysis conflicts, in these circumstances, with the line of cases defined by *Philadelphia National Bank*, holding that "[t]he views of a subsequent Congress form a hazardous basis for inferring the intent of an earlier one." *See* 374 U.S. at 348-49. Moreover, as the Seventh Circuit strongly suggested, the *Philadelphia National Bank* line is more in concert with the facts of this case. *See Paramount*, 138 F.3d at 710 ("Nothing in the [BBA] provisions themselves suggests a process of interpretation. . . .").

B. The Objective Circumstances of the Enactment of § 4714 Are at Odds With the Deference Given to That Statute by the Court of Appeals.

The language and architecture of Section 4714 indicate that it is a wholesale change in the law intended to create the authority that the four Circuits had found lacking in the prior statutes. Enacted purely as a budgetary measure, Section 4714 is not a mere interpretation or clarification of prior law.

Unlike the Ninth Circuit below, the Seventh Circuit recognized the logical difficulty with accepting Section 4714 as a "clarification" of prior law. As Judge Posner observed, Congress was not actually "interpreting" prior law when it passed its "clarification," but rather was overturning judicial interpretation of the law to create budgetary savings. Instead of a "clarification," [i]t is far more realistic to regard the 1997 [QMB] provisions as designed to change the original statute in order to reduce the cost of Medicaid to the federal government." *See Paramount*, 138 F.3d at 710.

> The location of the 1997 ["clarifying"] amendments in a statute labeled the "Balanced Budget Act" and concerned previously with cutting the federal deficit hardly creates confidence that Congress was, court-like, interpreting the 1986 statute. Nothing in the provisions themselves suggests a process of interpre-

> tation; they merely declare that the states are not required to reimburse [QMB] providers at the Medicare rate.

Id.

Section 4714 did not modify or elucidate the language of the original § 1396a(n) to provide the "cap" the Secretary argued was always contained within it. To the contrary, Section 4714 added a completely new provision to achieve that result. The new provision, designated 42 U.S.C. § 1396a(n)(2), provides that the states may now limit their co-payments for QMBs by capping physician payments at the lower state Medicaid fee schedules. App. 35a. Congress kept the original provision intact, renumbered as 1396a(n)(1). *Id.*

The original provision may not be rendered mere surplusage by Section 4714, according to the cardinal rule that all parts of a statute be given effect. *See Morton v. Mancari*, 417 U.S. 535, 551 (1974). The old Section 1396a(n) must therefore serve the purpose it always served, i.e., to make clear that the states would not violate their own Medicaid plans when making QMB payments at the higher Medicare rate, as explained in *Snider*. *See* 29 F.3d at 895.

Section 4714 contains two additional provisions which confirm that Congress substantively changed the law. First, in authorizing the states to pay less than the full Medicare cost sharing amounts, Section 4714 added—for the first time—provisions (designated as §§ 1396a(n)(3)(A) and (B)) which specifically state that the total of whatever payment is now made by the state (even if zero), plus the payment from Medicare (i.e., 80 percent of the Medicare rate), "shall be considered to be payment-in-full for the service" and that "the beneficiary [i.e., the QMB] shall not have any legal liability to a provider" for any unpaid amounts. These new provisions could only have been necessary to insulate QMBs against financial exposure otherwise created by the principal changes in the law (i.e., § 1396a(n)(2)), which, by authorizing the states

to pay less than the full Medicare cost-sharing amount, would have encouraged Physicians to seek cost-sharing from the QMBs themselves. Under the original (pre-Section 4714) statute, QMBs remained liable for any unpaid portion of their bills for items and services provided to them under the Medicare program, up to the full Medicare rate.

Viewed logically, the enacting Congress chose not to hold the QMBs harmless in this circumstance because it envisioned that the states would fulfill their obligations to pay the cost sharing in full, leaving no real financial exposure for the QMBs. In other words, the original statute did not specifically address this problem because Congress did not believe it had created the problem.

The new subsection 1396a(n)(3) also provides that its terms are not intended to prevent full payment for QMBs at the higher Medicare rate if the co-payments can be obtained from some other third-party source such as "a Medicare supplemental policy or an employer retiree health plan." App. 34a. This provision, likewise, was necessary only because Section 4714 gave the states a *new* option to "cap" their Medicare cost-sharing payments at the lower Medicaid schedule amounts.[3]

Standing alone, nothing in the language or construction of the amendments made by Section 4714 indicates that its purpose is anything other than a change in the law. Rather, the purported purpose of "interpreting" the statute originally enacted in 1986 is discernable only from the caption attached to the uncodified statute and the accompanying legislative history. The court of appeals in fact heavily relied on the title of Section 4714(a), despite its recognition that titles are not properly considered in statutory construction except where ambiguity exists (and none

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[3] In addition, the new law was given both an "effective" date and a purported "retroactive" application. App. 35a. A true "clarification" would require neither because it would merely elucidate the already present meaning of the original statute.

even arguably exists in the BBA amendments). *See* App. 13a-14a; 132 F.3d 1265-66 and n.6. Any contemplated reliance on those sources would fall squarely within the concerns expressed in *Philadelphia National Bank* against conclusive reliance on legislative history—particularly the discovered interpretations of a later Congress.

C. This Court's Guidance Is Required to Clarify the Bounds of Judicial Deference in These Circumstances.

All circuits that interpreted the relevant statute *before* the congressional "clarification" held against the interpretation urged by California and the Secretary. It was only *after* Section 4714 that the Ninth Circuit and the Seventh Circuit held to the contrary, in reliance on the *Loving* line of cases.

The Seventh Circuit followed *Loving* most reluctantly, noting that

> [W]e're in a quandary concerning the vitality of the *Loving* line, and would welcome clarification from the Supreme Court—pending which we feel constrained by *Loving* to give *some* weight to Congress' declaration in the Balanced Budget Act. . . . It is enough to tip the balance in favor of [the government's proffered interpretation] . . . and *while it seems to us that Paramount has the better interpretation,* there is sufficient ambiguity to require us to defer to the government.

Paramount, 138 F.3d at 711 (first emphasis in original; second emphasis added).

The Ninth Circuit gave no serious consideration to the *Philadelphia National Bank* line of cases. The court of appeals disposed of those decisions by limiting their concerns to unwarranted reliance on subsequent legislative history (as opposed to subsequent legislation) to interpret the meaning of a prior law. *See* App. 13a-14a; 132 F.3d at 1265-66. But the line between *Philadelphia National Bank* and *Loving* cannot be drawn so simply in this case, if in any.

First, as discussed in Section B., above, Congress' intent to "clarify" rather than change the law is, in fact, primarily evidenced in the title and legislative history of BBA Section 4714. App. 33a, 36a. Moreover, as discussed in Parts II and III, *infra*, the stated intent to "clarify" § 1396a(n) is encumbered by serious constitutional problems which should make the courts reluctant to grant uncritical deference to the clarification label. Perhaps most importantly, however, this Court has not viewed the line between reliance on subsequent legislation and reliance on subsequent legislative history to be as immutable as the Ninth Circuit believed.

This Court has stated, "We have observed on more than one occasion that the interpretation given by one Congress (or a committee or a Member thereof) to an earlier statute is of little assistance in discerning the meaning of that statute." *Public Employees Ret. System v. Betts*, 492 U.S. 158, 168 (1989). A later statute may, depending on the circumstances, have "little, *if any*, significance" in interpretation of the earlier enactment. *See Rainwater v. United States*, 356 U.S. 590, 593 (1958) (disregarding later statute) (emphasis added); *see also South Dakota v. Yankton Sioux Tribe*, 118 S. Ct. 789, 803 (1998) (same); *Gwaltney of Smithfield, Ltd. v. Chesapeake Bay Fdn., Inc.*, 484 U.S. 49, 63 n.4 (1987) (same); *Mackey v. Lanier Collection Agency & Serv.*, 486 U.S. 825, 839-40 (1988) (same).

In contrast to the Ninth Circuit in this case, the Seventh Circuit in *Paramount* suggested that the reasoning of *Philadelphia National Bank* may be more appropriate in circumstances like those here, where Congress' subsequent declaration of its predecessors' intent serves a wholly distinct budgetary purpose. *See* 138 F.3d at 709-10. Congress plainly sought to enhance the expected savings in future years by labeling the change in law a "clarification" and directing the result in cases interpreting the prior law. *Id.; see* App. 33a, 36a. Victory in pending cases would necessarily avoid payment of Medicaid matching funds

from the federal purse. *Cf.* App. 38a-42a (CBO report predicting savings in federal outlays over the next five years).

Even apart from Congress' pecuniary interest in directing the outcome in pending cases, the Seventh Circuit was troubled by the congressional intrusion. As that court noted, there is an "air of unreality" in suggesting that a subsequent Congress can clarify the intent of the body that met eleven years earlier, since "the membership of Congress had largely turned over during the interim and gress is not an interpretive body and has no felt duty to had been members of Congress back in 1986 and remembered what the membership's intentions had been regarding the esoteric issue of the reimbursement rate for providers of medical services to [QMBs]." *Paramount*, 138 F.3d at 709-10.

More fundamentally, Congress by nature is not well suited to interpret the meaning of earlier statutes. "Congress is not an interpretive body and has felt no duty to maintain continuity with the past." *Id.* at 710. That indeed is why "the views of a subsequent Congress form a hazardous basis for inferring the intent of an earlier one." *See Philadelphia Nat'l. Bank*, 374 U.S. at 348-49.

Yet both the Ninth Circuit below and the Seventh Circuit concluded that the *Loving* line of cases seems to offer no exception to the rule of deference even when a statute is used to heal a litigant's losses. Consequently, disappointed parties—here, the federal government and the states—are encouraged to "scurry to Congress" to try to repeal adverse judicial decisions through more favorable legislative interpretation. *See Paramount*, 138 F.3d at 710.

Certiorari should be granted to clarify the implications of the *Loving* and *Philadelphia National Bank* lines and resolve the "quandary" identified by the Seventh Circuit. *See S.E.C. v. United Benefit Life*, 387 U.S. 202, 207 (1967) (Supreme Court may grant certiorari to resolve

inconsistencies in its own decisions); *Paramount*, 138 F.3d at 711.

II. THE COURT OF APPEALS IMPROPERLY ELEVATED DEFERENCE TO CONGRESSIONAL "CLARIFICATION" ABOVE THIS COURT'S LONG-STANDING INTERPRETATIONS OF THE CONSTITUTIONAL SEPARATION OF POWERS DOCTRINE.

The court of appeals disposed of all separation-of-powers questions by determining, first, that the case was "pending" within the meaning of the effective date clause of Section 4714 and then holding:

> Because Congress thus has such authority to *change* the law as to pending cases, its power to *clarify* the law—to confirm what the law has always meant—follows a fortiori.

App. 12a; 132 F.3d at 1265.

This analysis reflects the traditional rule that courts are to apply the law in effect at the time of decision, *see United States v. Schooner Peggy*, 1 Cranch (5 U.S.) 103, 110 (1801), but begs the more serious and fundamental question as to whether Congress' act was, in the first instance, an impermissible intrusion into the judicial function. In *United States v. Klein*, 13 Wall. (80 U.S.) 128 (1872), this Court made clear that Congress may not prescribe a new rule of decision in pending cases to benefit the United States.

Klein concerned a legislative effort by Congress to "clarify" (i.e., re-define) the rules of decision for certain claims against the United States. The Court held, in the form of questions, that, if it were to heed the congressional instruction, it would be "allowing one party to the controversy to decide it in its own favor" and that to do so would be to permit the legislature to "prescribe rules of decision to the Judicial Department . . . in cases pending before it." *Id.* at 146. This constitutional aversion

was then repeated: "Can it [Congress] prescribe a rule in conformity with which the court must deny to itself the jurisdiction thus conferred [over appeals from the Court of Claims], because and only because its decision, in accordance with settled law, must be adverse to the government and favorable to the suitor? This question seems to answer itself." *Id.* at 147.

As this Court has since noted, "of obvious importance to the *Klein* holding was the fact that Congress was attempting to decide the controversy at issue in the Government's own favor." *United States v. Sioux Nation*, 448 U.S. 371, 405 (1980). "[E]ven more important, the proviso at issue in *Klein* had attempted 'to prescribe a rule for the decision of a cause in a particular way.'" *Id.* (quoting *Klein*, 13 Wall. at 146).

The meaning of *Klein* has been debated by courts and the decision has been described as forbidding Congress to prescribe rules of decision for pending cases without amending the law. Even one decision of this Court, in dicta, so confined *Klein*, stating that the 1992 decision in *Robertson v. Seattle Audubon Society*, 502 U.S. 429, 441 (1992) had modified *Klein* despite that decision's express refusal to do so. *See Plaut v. Spendthrift Farm, Inc.*, 514 U.S. 211, 218 (1995) (quoting *Robertson*, 503 U.S. at 441, in part for the proposition that the prohibition of *Klein* "does not take hold when Congress 'amends applicable law'"); *but see Robertson*, 503 U.S. at 441 (stating that the Court "need not consider whether this reading of *Klein* is correct" because it disagreed with lower court as to whether the statute at issue had amended applicable law).

Even if *Klein* is to be read merely as *Plaut* described it, Section 4714 is constitutionally flawed. Its retroactive aspect affects only a discrete and readily-identifiable category of cases—those in which health care providers have asserted their rights to payment under the prior law. It sweeps no more broadly. It affects no other payments

made, or to be made, for services provided before the effective date. Article III of the Constitution denies Congress the power to enact such a narrowly retroactive statute. *See* App. 24a; *Plaut*, 514 U.S. at 228; *Klein*, 13 Wall. (80 U.S.) at 146-47. The Ninth Circuit's declination to examine this flaw is doubly inappropriate because the prescribed rule of decision eliminates the United States' obligation to fulfill a bargain previously struck to pay for services already performed. *See United States v. Carlton*, 512 U.S. 26, 39-40 (1994) (Scalia, J., concurring) (legislation "eliminating the specifically promised reward for costly action *after* the action has been taken, and refusing to reimburse the cost" is "harsh and oppressive" beyond bounds of Court's substantive due process test) (emphasis in original).

Whatever the exact scope of *Klein*, it must at least mean that Congress violates the separation of powers when that body alters the outcome of pending cases to benefit the federal government. *Sioux Nation* recognized this point, *see* 448 U.S. at 405, and the language of *Klein* has not been disturbed. This case, and others on appeal when the BBA was enacted, involve the federal government as a financially interested party. Section 4714 violated the core holding of *Klein* by intervening to save the government the money it would have lost had the Physicians and other plaintiffs prevailed.

Medicaid is a joint federal-state venture.[4] Application of Section 4714 to pending cases saves money for both the state and federal governments. *See* App. 41a (Con-

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[4] *See Michigan Hosp. Ass'n v. Dept. of Social Services*, 738 F. Supp. 1080, 1081 (W.D. Mich. 1990) (describing Medicaid as "a federal-state joint venture"); *see also Wilder v. Virginia Hosp. Ass'n*, 496 U.S. 498, 502 (1998) (Medicaid is a "cooperative" federal-state program); *Harris*, 448 U.S. at 308 (same); *Bowen v. Massachusetts*, 487 U.S. 879, 883 (1987) (same); *Illinois Health Care Ass'n v. Shalala*, 776 F. Supp. 411, 413 (N.D. Ill. 1991), *aff'd*, 983 F.2d 1460 (CA7 1993) (Medicaid is a "joint" federal-state enterprise).

gressional Budget Office estimates of net *federal* savings from Section 4714 totaling $2.1 billion by 2002 and $5.6 billion by 2007). The federal government contributes at least 50 percent of the money used for the cost-sharing payments sought by plaintiffs in this and similar cases, *see* 42 U.S.C. § 1396d(b), and cannot credibly deny the necessary financial effect on it from the application of Section 4714 to pending lawsuits. *Paramount*, 138 F.3d at 710 (1997) (QMB enactment appears to have been "designed to change the original statute in order to reduce the cost of Medicaid to the federal government").

The QMB patients for whom services have been provided are beneficiaries of Medicare, a wholly federal program. The federal government is inextricably involved in the programs at issue, and will benefit financially from the Ninth Circuit's uncritical deference to the congressional "clarification."

Retroactive application of any statute is limited by the Constitution. *See Landgraf v. USI Film Products*, 511 U.S. 244, 267 (1994) (citing provisions other than Article III). Basic separation of powers principles require an exception here to the general rule that courts must apply the law in existence at the time of decision to "pending" cases. Were it not so, few, if any, obstacles to congressional interference with the judicial function would exist. Unfettered application of § 4714 here will, as in *Klein*, effectively determine the outcome of particular cases pending against the federal government and resolve them in the government's favor to its significant financial benefit.

The Ninth Circuit, in deferring to the congressional act, ignored these principles and, in so doing, created an exception to the Constitution that has no basis in this Court's interpretation of Article III. Certiorari should be granted in light of continuing controversy over the meaning of *Klein*, particularly when applied, as here, to an issue capable of recurring in every cycle of budgetary

legislation. *See Continental T.V., Inc. v. GTE Sylvania, Inc.*, 433 U.S. 36, 47-48 (1977).

III. THE NINTH CIRCUIT BELOW IGNORED THE CONSTITUTIONAL CONTRACT CLAUSE, TAKINGS, AND DUE PROCESS PROBLEMS CREATED BY DEFERENCE TO THE CONGRESSIONAL "CLARIFICATION".

The Ninth Circuit's opinion below barely acknowledged, and did not address, the serious Fifth Amendment takings and due process and Contract Clause issues raised by Congress' effort to label Section 4714 as a "clarification" of prior law and California's certain action in reliance on it. Instead of considering these issues as a factor which might militate against judicial deference to the legislature, the court below found that it must "honor Congress' 'clarification' label . . . [which] moots all of appellees' constitutional objections to the new legislation." App. 15a; 132 F.3d at 1266. In so doing, the Ninth Circuit swept away a long line of this Court's decisions invalidating efforts by Congress to repudiate the contractual obligations of the United States.

This Court recently reiterated that ordinary contract principles apply to government agreements and that the federal government may not retroactively eliminate its own debts to save money. *See United States v. Winstar Corp.*, 116 S. Ct. at 2459-60 and n.28, 2464-65 and n.39, 2468, n.51 (plurality opinion), 2475-76 (Breyer, J., concurring), 2478-79 (Scalia, J., concurring); *see also Bowen v. Public Agencies Opposed to Social Security Entrapment*, 477 U.S. 41, 55 (1986). This Court noted that the most protectable of government contracts with private parties are those in procurement or similar situations. *Winstar*, 116 S.Ct. at 2457. Here, both the procurement and the rendition of services by contractors (the Physicians) had already been completed under existing law.

Section 4714 existinguishes obligations due and owing under prior law. Even Congress recognized that the services here have already been provided. See BBA § 4714(c) (App. 35a) (amendments "shall also apply to payment by a State for items and services furnished before" date of enactment if subject of a lawsuit). The law in effect when the Plaintiffs provided services, in 42 U.S.C. §§ 1396a(a)(10)(E) and 1396d(p)(3), required payment to them at the Medicare rate—including Part B cost-sharing from state and federal Medicaid funds. *See Kozlowski*, 42 F.3d at 1459-60; *Haynes*, 36 F.3d at 1076-77; *Snider*, 29 F.3d at 894-95, 903; *Perales*, 954 F.2d at 809-63. Those rights were assigned to the Physicians as required by 42 U.S.C. § 1395w-4(g)(3)(A). The Physicians' rights to payment were vested.[5] An implied contract also arises after services are rendered under a law specifying compensation to be paid at the amount fixed. *See Robertson v. Miller*, 276 U.S. 174, 179 (1928). Rights under government contracts are properly protected by both the Due Process and Takings Clauses, as well as the Contract Clause as against a state. *See* App. 24a; *United States Trust Co. v. New Jersey*, 431 U.S. 1, 22, 29 (1977) (Contract Clause); *Thorpe v. Housing Authority*, 393 U.S. 268, 278 n.31

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[5] The Plaintiffs performed medical services for QMBs under "participation" agreements which obligated them to accept assignment of a Medicare beneficiary's right to payment, 42 U.S.C. § 1395u(h) (App. 25a), and limited them to recovery of 100 percent of the Medicare-approved charge. *See id.* § 1395u(b)(3)(B)(ii). Suppliers of services to QMBs are required to sign participation contracts. *Id.* § 1395w-4(g)(3)(A) (App. 26a). The Medicare Part B participation agreement for physicians contemplates that they will receive full payment, stating that a doctor "shall not collect from the beneficiary or other person or organization [such as an insurer] more than the applicable deductible and coinsurance." App. 50a. *See* 42 U.S.C. § 1320a-7b(d). The Physicians also had provider agreements with Medi-Cal, and the federal government had promised QMBs it would pay cost-sharing—a promise to which the Physicians were intended third-party beneficiaries. *See* App. 49a; *Britton v. Co-Op Banking Group*, 4 F.3d 742, 745 (9th Cir. 1993) (explaining third-party beneficiary law).

(1969) (due process); *Lynch v. United States*, 292 U.S. 571, 579 (1934) (takings); *Madera Irrig. Dist. v. Hancock*, 985 F.2d 1397, 1401 (CA9 1993) (takings); *Minnesota Assn. of Health Care v. Minn. Dept. of Pub. Welfare*, 742 F.2d 442, 450-51 (CA8 1984) (Contract Clause); *Caritas Services, Inc. v. Washington*, 869 F.2d 28, 41 (Wash. 1994) (Contract Clause); *Oberlander v. Perales*, 740 F.2d 116, 120 (CA2 1984) (due process); *but see Connolly v. Pension Benefit Guaranty Corp.*, 475 U.S. 211, 224 (1986) (leaving extent of protection by Takings Clause undecided).[6]

All four opinions in *Winstar* recognized similar rights as protectable against retroactive abrogation by the sovereign, relying on this Court's long-standing decisions in *Lynch*, 292 U.S. 571, and *Perry v. United States*, 294 U.S. 330 (1935), "the two principal cases of this century holding that the government may not simply repudiate its contractual obligations." *See id.* at 2478 (Scalia, J., concurring, joined by two justices); *see also* 116 S.Ct. at 2455, 2559-60 & n.28, 2464-65 & n.39, 2468-69 (plurality opinion); *id.* at 2473 (Breyer, J., concurring); *id.* at 2481 (Rehnquist, C.J., dissenting). Both *Lynch* and *Perry* make clear that congressional abrogation of the "essential bargain" of a contract is "impermissible repudiation." *Winstar*, 116 S.Ct. at 2479 (Scalia, J., concurring); *see Perry*, 291 U.S. at 435; *Lynch*, 292 U.S. at 580.

Through Section 4714, the United States and the State of California seek to retroactively avoid contractual rights even more worthy of protection than the prospective insurance benefits at issue in *Lynch*. *See* 292 U.S. at 580-81. The attempted avoidance violates both the takings clause and the due process guarantee of the Fifth Amendment and (as against California) the Contract Clause. *See*

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[6] Actions of state governments in a joint relationship involving federal action may be attributed to the United States for takings purposes. *See Preseault v. United States*, 100 F.3d 1525, 1551 (CA Fed. 1996) (en banc).

Lynch; *United States Trust Co.*; *Perry*; *cf. United States v. Larionoff*, 431 U.S. 864, 880 (1977) (intimating that Congress may not deprive service member of pay due for duties already performed). The benefit that the United States will derive from retroactive application of Section 4714 cannot be overlooked. "[I]t makes sense to scrutinize governmental action more closely when the State stands to benefit." *Harmelin v. Michigan*, 501 U.S. 957, 978 n.9 (1991) (citing *Perry*, 294 U.S. at 350-51). The United States will avoid the obligation to pay matching funds to the states through the effect of Section 4714, the CBO has reported. App. 41a.

The Ninth Circuit's failure to address these constitutional concerns elevates deference to a purported congressional clarification above the Physicians' vested property interests. Certiorari should be granted to re-establish the vitality of *Lynch* and *Perry* in these circumstances and to sustain the Physicians' Contract Clause rights.

IV. CERTIORARI SHOULD BE GRANTED TO RESOLVE THE CONFLICT IN THE CIRCUITS REGARDING THE STATES' OBLIGATIONS TO PAY MEDICARE COST SHARING ON BEHALF OF QMBS WITH RESPECT TO SERVICES RENDERED PRIOR TO AUGUST 5, 1997.

Although fairly implicated by Petitioners' request that this Court provide guidance as to the weight to be given to the retroactive budgetary "clarification" of the QMB payment provisions, it also is important for this Court explicitly to resolve the conflict thus engendered over the correct interpretation of the QMB provisions as they existed before the Balanced Budget Act.

As described above, the four Circuits held that the plain meaning of 42 U.S.C. § 1396a(a)(10)(E), requiring states to "make available" medical assistance for (i.e., to cover) "medicare cost-sharing," combined with the explicit definition of "medicare cost sharing" at 42 U.S.C. § 1396d (p)(3), was clear and did not permit the limitations urged

by the states and the Secretary. Consequently, the four Circuits rejected the Secretary's position that 42 U.S.C. § 1396a(n) allowed the states, at their option, to "make available" something less, or even nothing, and thereby to ignore and eviscerate § 1396a(a)(10)(E). The four Circuits collectively analyzed the statutory scheme at length and concluded that the Secretary's position was due no deference under *Chevron* principles. *See Kozlowski*, 42 F.3d at 1446-60; *Snider*, 29 F.3d at 888-903; *Haynes*, 36 F.3d at 1076-77; *Perales*, 954 F.2d at 856-63.

The Seventh and Ninth Circuits, with far less analysis of the statute, and expressly influenced by the later Congress' view that the four Circuits had misinterpreted the statutory language of the enacting Congress, found that the original statutes were ambiguous and that the Secretary's interpretation, as "clarified" by Congress, should prevail. Neither court discussed the meaning of 42 U.S.C. §§ 1396a(a)(10)(E) or 1396d(p)(3) in detail, the Ninth Circuit specifically electing to "eschew any analysis" of the statutes without even any citation to them. *See Beverly Comm. Hosp.*, 132 F.3d at 1264; App. 10a; *see also Paramount*, 138 F.3d at 707-09.

Although inextricably intertwined with the question of deference to the later enactment, the conflict in the circuits undermines this Court's foundational rules of statutory construction that enactments are to be given their plain meaning and the words of the statute are deemed the best indicators of congressional intent. *See e.g., Connecticut Nat'l Bank v. Germain*, 503 U.S. 249, 253-254 (1992); *Richards v. United States*, 369 U.S. 1, 9 (1962). Likewise, the conflicting interpretations distort this Court's teaching that if legislative history must be consulted, it is the intent of the enacting Congress, not the opinions of a subsequent one, that is controlling. *See Pierce v. Underwood*, 487 U.S. 552, 566-67 (1988) (commenting, in this context, that interpretation of enacted statute is a function of the courts "and not the legislature"); *Oscar Mayer & Co. v. Evans*, 441 U.S. 750, 758 (1979). Certiorari

should be granted to resolve the conflict among the circuits.

CONCLUSION

For the foregoing reasons, a writ of certiorari should issue to review the judgment of the United States Court of Appeals for the Ninth Circuit.

Respectfully submitted,

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APPENDIX

APPENDIX

APPENDIX

UNITED STATES COURT OF APPEALS
NINTH CIRCUIT

Nos. 97-55022, 96-55208, 97-55713, 96-56249, 96-56485, 96-56648, 96-56699 and 96-56745

BEVERLY COMMUNITY HOSPITAL ASSOCIATION, a California non-profit public benefit corporation, d/b/a Beverly Hospital; BELLWOOD MEDICAL CORPORATION, d/b/a Bellwood General Hospital; CHICO COMMUNITY HOSPITAL MEDICAL CENTER, INC., d/b/a Chico Community Rehabilitation Hospital, d/b/a Chico Community Hospital; HOLLYWOOD COMMUNITY HOSPITAL MEDICAL CENTER, INC., d/b/a Hollywood Community Hospital Of Van Nuys, d/b/a Hollywood Community Hospital Of Hollywood; LANCASTER HOSPITAL CORPORATION, d/b/a Lancaster Community Hospital, *et al.*,
Plaintiffs-Appellees,

v.

KIMBERLY BELSHE, Director of the California Department of Health Services,
Defendant-Appellant.

CALIFORNIA AMBULANCE ASSOCIATION,
Plaintiff-Appellee,

v.

DONNA E. SHALALA, Secretary of the United States Department of Health and Human Services,
Defendant,

and

KIMBERLY BELSHE, Director of the California Department of Health Services,
Defendant-Appellant.

CALIFORNIA AMBULANCE ASSOCIATION,
Plaintiff-Appellee,

v.

DONNA E. SHALALA, Secretary of United States Department of Health and Human Services,
Defendant-Appellant.

CALIFORNIA MEDICAL ASSOCIATION; CALIFORNIA ACADEMY OF FAMILY PHYSICIANS; CALIFORNIA SOCIETY OF ANESTHESIOLOGISTS; CALIFORNIA UROLOGICAL ASSOCIATION; CALIFORNIA CHAPTER OF THE AMERICAN COLLEGE OF EMERGENCY PHYSICIANS; CALIFORNIA CHAPTER OF THE AMERICAN COLLEGE OF CARDIOLOGY; CALIFORNIA SOCIETY OF INTERNAL MEDICINE; CALIFORNIA SOCIETY OF PHYSICAL MEDICINE & REHABILITATION; CALIFORNIA RADIOLOGY SOCIETY, CHAPTER OF THE AMERICAN COLLEGE OF RADIOLOGY,
Plaintiffs-Appellees,

v.

DONNA E. SHALALA, Secretary of United States Department of Health and Human Services; S. KIMBERLY BELSHE, Director of the California Department of Health Services,
Defendants-Appellants.

RICHARD GILMORE, M.D.; PRATAP SARAF, M.D.,
Plaintiffs-Appellees,

v.

DONNA E. SHALALA, Secretary of the United States Department of Health and Human Resources,
Defendant,

S. KIMBERLY BELSHE, Director of Health Services,
Defendant-Appellant.

RICHARD GILMORE, M.D., individually and on behalf of all those similarly situated; PRATAP SARAF, M.D., individually and on behalf of all those similarly situated,
Plaintiffs-Appellees,

v.

DONNA E. SHALALA, Ph.D., Secretary of the United States Department of Health and Human Services; S. KIMBERLY BELSHE, Director of the California Department of Health Services,
Defendants-Appellants.

CALIFORNIA MEDICAL ASSOCIATION; CALIFORNIA ACADEMY OF FAMILY PHYSICIANS; CALIFORNIA SOCIETY OF ANESTHESIOLOGISTS; CALIFORNIA UROLOGICAL ASSOCIATION; CALIFORNIA CHAPTER OF THE AMERICAN COLLEGE OF EMERGENCY PHYSICIANS; CALIFORNIA CHAPTER OF THE AMERICAN COLLEGE OF CARDIOLOGY; CALIFORNIA SOCIETY OF INTERNAL MEDICINE; CALIFORNIA SOCIETY OF PHYSICAL MEDICINE & REHABILITATION; CALIFORNIA RADIOLOGY SOCIETY, CHAPTER OF THE AMERICAN COLLEGE OF RADIOLOGY,
Plaintiffs-Appellees,

v.

DONNA E. SHALALA, Secretary of the United States Department of Health and Human Sesources,
Defendant-Appellant.

DONALD R. MACPHERSON, JR., as Successor in interest to decedent Christina MacPherson & MacPherson Oil Company Employee Welfare Benefit Plan,
Plaintiff-Appellant,

v.

EMPLOYERS HEALTH INSURANCE,
Defendant-Appellee.

Appeal from the United States District Court
for the Central District of California
J. Spencer Letts, District Judge, Presiding
D.C. Nos. CV-95-04053-JSL, CV-96-02322-JSL,
CV-96-2322-JSL, CV-03033-JSL, CV-96-05564-JSL,
CV-96-03033-JSL, CV-97-00514-JSL

Argued and Submitted Oct. 6, 1997
Decided Dec. 2, 1997

Before: REINHARDT and TASHIMA, Circuit Judges, and SHADUR, District Judge.*

SHADUR, District Judge:

We address here a question of first impression, not only in this Circuit but (understandably in light of the recency

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* The Honorable Milton I. Shadur, United States District Judge for the Northern District of Illinois, sitting by designation.

of the legislation involved) in any court: whether a congressional enactment adopted in August 1997, but stating that it is retroactive and applicable to pending cases, calls for approval of the reading that has been given to the pre-enactment version of the same legislation by the Secretary of the United States Department of Health and Human Services ("Secretary"). Because we answer that question in the affirmative, we reverse all three decisions below.[1]

All three of these sets of appeals pose a common problem: whether the State of California may choose to limit certain payments, as required by statute to be made to enroll poor people—qualified Medicare beneficiaries ("QMBs")—in the Medicare insurance program, to the amount by which California's Medicaid rate exceeds what Medicare has paid. Those payments, required from all participating states under the Medicaid Act, extend to deductibles, coinsurance and copayments that the QMBs cannot bear fully and that the State is required to pay on their behalf (whether totally or in part is at stake in these cases).

Title XVIII of the Social Security Act (the "Medicare Act," 42 U.S.C. §§ 1395-1395ccc[2]) provides a federal health insurance program for elderly and disabled persons. Medicare Part A covers inpatient hospital services and certain related benefits (Sections 1395c-1395i-4), and it is provided automatically for individuals entitled to Social Security retirement or disability benefits (Section 426). Medicare Part B is a voluntary program under which Medicare-eligible persons can obtain supplemental insurance for various outpatient services from physicians and other providers(Sections 1395j-1395w-4). It is financed

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[1] In each instance the jurisdiction of the district court was based upon 28 U.S.C. § 1331. All three judgments are appealable pursuant to 28 U.S.C. § 1291.

[2] All further citations to Title 42 provisions will take the form "Section-," utilizing the Title 42 numbering system rather than the internal numbering of the Acts involved.

by a combination of federal funds and premiums paid by or on behalf of eligible individuals (Sections 1395r, 1395t (g)). Both Medicare Part A and Medicare Part B call for payments by covered individuals that constitute the deductibles, coinsurance and copayments referred to earlier.

Title XIX of the Social Security Act (the "Medicaid Act," Sections 1396-1396v) is a cooperative federal-state program that provides federal matching funds to states that elect to provide medical services to certain needy individuals (see Section 1396; *Harris v. McRae*, 448 U.S. 297, 301, 100 S.Ct. 2671, 2680, 65 L.Ed.2d 784 (1980)). Although states are not required to participate in Medicaid, if they elect to do so they must follow federal guidelines (*Harris*, 448 U.S. at 301, 100 S.Ct. at 2680) and must submit for Secretary's approval their state plans that describe the states' intended means for insuring compliance with those guidelines (Section 1396a(b)).

What is at issue in these three sets of appeals is the area of overlap between the Medicare and Medicaid Acts where coverage for the elderly poor is involved. Those persons are often entitled to participate in such coverage but may not be able to afford to pay the required deductible and coinsurance amounts under Medicare Part A or the premiums and payments needed to enroll in Medicare Part B. At the time that the various lawsuits were filed below, Congress had dealt with individuals who are eligible for both Medicare and Medicaid (see Section 1396d (p)(1)) by stating in Section 1396a(n) of the Medicaid Act what the state plans could set up to cover their obligations on behalf of the QMBs involved.

Three types of plaintiffs (now appellees) are involved in these appeals. *Beverly Hospital* is a class action on behalf of all California hospitals that provide inpatient hospital services under the Medicare and Medicaid Acts. *California Ambulance* involves two types of associations, California Ambulance Association and physician associations including California Medical Association, each type

of association also representing providers of services under the two statutes. And *Gilmore* was brought by two doctors who provide outpatient physician services to persons under the two statutes.[3] Thus *Beverly Hospital* involves Medicare Part A, while *California Ambulance* and *Gilmore* implicate Medicare Part B.

Secretary is an appellant in all of the cases except for *Beverly Hospital,* in which she was given leave to participate as an amicus curiae. Director S. Kimberly Belshe of the California Department of Health Services ("Director") is an appellant in all of the cases. Both appellants subscribe to Secretary's legal position pursuant to which California adopted its Medicaid state plan ("Medi-Cal"), which position asserts that under Section 1396a(n) participating States such as California have the choice to limit their payments as described earlier, so that they need not pay the *full* cost-sharing amount. In each of the cases before us the District Court rejected that contention, as have all four Courts of Appeals that have addressed the question: *Rehabilitation Ass'n of Virginia, Inc. v. Kozlowski,* 42 F.3d 1444 (4th Cir.1994) ("*Kozlowski*"); *Haynes Ambulance Serv., Inc. v. State of Alabama,* 36 F.3d 1074 (11th Cir.1994 ("*Haynes*"); *Pennsylvania Med. Soc'y v. Snider,* 29 F.3d 886 (3d Cir.1994) ("*Snider*"); and *New York City Health and Hosps. Corp. v. Perales,* 954 F.2d 854 (2d Cir.1992) ("*Perales*").[4]

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[3] Although the *Gilmore* case was originally intended to be a class action, any need for class certification was obviated when defendants agreed that the result in the case would be followed as to all persons providing such services.

[4] Although this does not affect our resolution of these cases in light of what follows, it is worth noting that those four Courts of Appeals have employed divergent approaches (reading the statute differently) in reaching their conclusions. And it may be added that those four decisions (and the decisions now on appeal) do not at all reflect a unanimous judicial reaction: For example, two recent District Court decisions, *Dameron Physicians Med. Group v. Shalala,* 961 F.Supp. 1326 (N.D.Cal.1997) and *Kulkarni v. Leean,*

After the scheduled briefing of these appeals had been completed, Congress entered the picture. Its Balanced Budget Act of 1997 ("Act"), signed into law by the President on August 5 of this year, included as Act § 4714 a provision that expressly amends Section 1396a(n) to adopt the position advanced by Secretary and Director here:

> (2) In carrying out paragraph (1), a State is not required to provide any payment for any expenses incurred relating to payment for deductibles, coinsurance, or copayments for medicare cost-sharing to the extent that payment under title XVIII for the service would exceed the payment amount that otherwise would be made under the State plan under this title for such service if provided to an eligible recipient other than a medicare beneficiary.
>
> (3) In the case in which a State's payment for medicare cost-sharing for a qualified medicare beneficiary with respect to an item or service is reduced or eliminated through the application of paragraph (2)-
>
> > (A) for purposes of applying any limitation under title XVIII on the amount that the beneficiary may be billed or charged for the service, the amount of payment made under Title XVIII plus the amount of payment (if any) under the State plan shall be considered to be payment in full for the service;
> >
> > (B) the beneficiary shall not have any legal liability to make payment to a provider or to an organization described in section 1903(m)(1)(A) for the service; and
> >
> > (C) any lawful sanction that may be imposed upon a provider or such an organization for

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No. 96 C 884-S, 1997 WL 527674 (W.D. Wis. June 23), have joined other lower court decisions going the other way. See also the discussion of the problem at 66 U.S.L.W. 2233 (Oct. 21, 1997).

> excess charges under this title or title XVIII shall apply to the imposition of any charge imposed upon the individual in such case.
>
> This paragraph shall not be construed as preventing payment of any medicare cost-sharing by a medicare supplemental policy or an employer retiree health plan on behalf of an individual.

There is no dispute among the litigants that if this new statutory provision (which Congress has captioned "Clarification Regarding State Liability for Medicare Cost-Sharing") is applicable, it requires the reversal of the District Court's decisions. One minor variant exists: Beverly Hospital contends that a remand is necessary because Secretary's methodology, as applied to that hospital's situation, does not mesh with the new enactment. We speak briefly to that question later.

Because Congress was deliberately targeting what were known to be existing disputes on this subject, Act § 4714 (c) went on to prescribe a retroactive effective date of the quoted amendment:

> (c) EFFECTIVE DATE.—The amendments made by this section shall apply to payment for (and with respect to provider agreements with respect to) items and services furnished on or after the date of the enactment of this Act. The amendments made by subsection (a) shall also apply to payment by a State for items and services furnished before such date if such payment is the subject of a law suit that is based on the provisions of sections 1902(n) and 1905(p) of the Social Security Act [5] and that is pending as of, or is initiated after, the the date of the enactment of this Act.

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[5] Those cited sections of the Social Security Act respectively correspond to Sections 1396a(n) and 1396d in the Title 42 usage employed in this opinion. Those sections are in fact the statutory provisions involved in these appeals.

That being the case, the relevant considerations in our three cases have shifted from those that had occupied the parties' entire scheduled briefing, which (as stated earlier) had been completed before the congressional enactment. We therefore invited and received supplemental briefing on the effect of Act § 4714 on these cases. And having done so, we eschew any analysis of those original arguments and turn instead to the validity and applicability of the August 1997 enactment.

Standard of Review

Both because constitutional questions are at issue and because the cases come up on summary judgment, we engage in a de novo review of the district courts' final judgments (*Gray v. First Winthrop Corp.*, 989 F.2d 1564, 1567 (9th Cir.1983) ("The constitutionality of a statute is a question of law which we review de novo"); *Brinson v. Linda Rose Joint Venture*, 53 F.3d 1044, 1047 (9th Cir. 1995) (holding that an order granting summary judgment is reviewed de novo). Each of the issues before us will be examined through that lens.

Application of Act § 4714

At the outset we examine the coverage of these appeals by the new legislation—a matter that was challenged in the appellees' briefs but was not addressed by their counsel during oral argument. As the earlier-quoted Act § 4713 (c) states, the new amendments apply to any payments by a State for items and services furnished pre-enactment as long as the payment "is the subject of a lawsuit . . . that is pending as of . . . the date of the enactment of this Act." In that respect it does not matter whether the congressional labeling of the new legislation as simply a "clarification" has to be credited by a court (a subject that we deal with in a moment). What is instead significant is that Congress' characterization plainly reflects its intention to resolve every still-live dispute in the manner

specified by the new legislation. Hence the statutory reference to "pending" lawsuits must be construed as embracing not only undecided cases at the District Court level but also actions pending on appeal, such as the ones before us.

We have previously ascribed precisely that meaning to the term "pending" in *Gray*, 989 F.2d at 1571. There we cited and quoted from numerous earlier decisions upholding Congress' power to impact the results in cases still "pending" on appeal without running afoul of separation of powers principles:

> These cases are properly construed as "pending" cases for separation of powers purposes. *See Griffith v. Kentucky*, 479 U.S. 314, 321 n. 6, 107 S.Ct. 708, 712 n. 6, 93 L.Ed.2d 649 (1987) (judgment is "final" and case is no longer pending only after "the availability of appeal [is] exhausted, and the time for a petition for certiorari [has] elapsed or a petition for certiorari finally [has been] denied"); *see also Georgia Ass'n of Retarded Citizens v. McDaniel*, 855 F.2d 805, 813 (11th Cir.1988) ("When it so intends, [Congress'] ability to affect the content of a nonfinal judgment in a civil case, through retroactive legislation ceases only when a case's journey through the courts comes to an end."), *cert. denied*, 490 U.S. 1090, 109 S.Ct. 2431, 104 L.Ed.2d 988 (1989); *de Rodulfa v. United States*, 461 F.2d 1240, 1253 (D.C. Cir.) ("[T]he suit is pending until the appeal is disposed of, and until disposition any judgment appealed from it is still *sub judice*.") (internal quotations omitted), *cert. denied*, 409 U.S. 949, 93 S.Ct. 270, 34 L.Ed. 220 (1972).

And what *Gray, id.* then said, albeit in the different context of a change in a statute of limitations, applies with equal force to give identical content to the word "pending" in Act § 4714(c):

> Because none of the cases here have completed their journey through the appellate process, Congress has the authority to change the underlying substantive law by altering the statute of limitations in a way that affects those pending cases.

Because Congress thus has such authority to *change* the law as to pending cases, its power to *clarify* the law—to confirm what the law has always meant—follows a fortiori.

That being the case, the next line of inquiry is whether the new enactment is valid in its application to such pending cases. On that score a key threshold issue is whether the enactment was truly a "clarification" of the prior statute (as Congress said), or was instead a substantial change in the law. If Act § 4714 were to be characterized in the latter fashion, its retroactive application would pose a series of potential constitutional problems. If however Act § 4714 merely clarifies what Section 1396a(n) was originally intended to mean, then the Medicaid Act never required states such as California to pay cost-sharing in full. In that event the only function of Act § 4714 in this situation is to state more clearly what the law already was —it has no retroactive effect that might be called into constitutional question. Because appellees do not dispute the constitutionality of the prospective application of Act § 4714, if that provision merely clarifies Section 1396a (n) there are also no potential constitutional problems with the application of the enactment to these pre-Act cases.

As already indicated, Congress expressly (and formally) stated as its intention that the new provision in Act § 4714 was a "clarification" of the payment rules contained in Section 1396a(n). It has been established law since nearly the beginning of the republic (as demonstrated by *Red Lion Broadcasting Co. v. FCC*, 395 U.S. 367, 381-82 & n. 8, 89 S.Ct. 1794, 1801-02 & n. 8, 23 L.Ed.2d 371 (1969) and earlier cases cited there) that congres-

sional legislation that thus expresses the intent of an earlier statute must be accorded great weight (see most recently *Loving v. United States*, 517 U.S. 748, ——, 116 S.Ct. 1737, 1749, 135 L.Ed.2d 36 (1996), quoting the *Red Lion* language as earlier repeated in *Consumer Product Safety Comm'n v. GTE Sylvania*, 447 U.S. 102, 118 n. 13, 100 S.Ct. 2051, 2061 n. 13, 64 L.Ed.2d 766 (1980); and see also the plurality opinion in *United States v. Winstar Corp.*, 518 U.S. 839, ——, 116 S.Ct. 2432, 2463, 135 L.Ed.2d 964 (1996) (speaking in terms of "signficant weight")).

Other cases that question the competence of a later Congress to opine on the intended meaning of an earlier statute are readily distinguishable. All of those cases have involved attempts to use less formal types of subsequent legislative history, particularly Senate and House Committee Reports, to infer the meaning of prior enactments (*United States v. Southwestern Cable Co.*, 392 U.S. 157, 170, 88 S.Ct. 1994, 20 L.Ed.2d 1001 (1968), rejecting the use of congressional opinions contained solely in House Committee Reports; *Oscar Mayer & Co. v. Evans*, 441 U.S. 750, 758, 99 S.Ct. 2066, 2072-73, 60 L.Ed.2d 609 (1979), rejecting the use of congressional opinions expressed only in Senate report; and see *Mackey v. Lanier Collection Agency & Serv., Inc.*, 486 U.S. 825, 839-40, 108 S.Ct. 2182, 2190-91, 100 L.Ed.2d 836 (1988), rejecting the use not only of a later House Committee Report but also of the later enactment as such as bases for ininferring the intent of an earlier Congress). By contrast, here Congress has formally declared Act § 4714 to be a clarification of Section 1396a(n) in the title of the Act as well as in the Committee Reports.[6] Such formal legislative

[6] While titles of acts are not part of the law, they can be used to resolve ambiguity in a statute, so long as they do not contradict the actual text (see, e.g., *INS v. National Ctr. for Immigrants' Rights, Inc.*, 502 U.S. 183, 189, 112 S.Ct. 551, 555-56, 116 L.Ed.2d 546 (1991) and cases cited there). In this instance, the congressional

action squarely fits the *Red Lion* mold as so often (and so recently) reconfirmed by later cases, so that Act § 4714 is entitled to great weight in construing the meaning of Section 1396a(n).

Appellees contend that Act § 4714 effected such a substantial change in federal law in terms of the government's liability to health care providers that it cannot be treated as simply clarifying Section 1396a(n). But that argument proceeds from the premise that Section 1396a(n)'s meaning was clear enough so as to need no further explanation. Not only does that premise ignore the split of authority construing the statute (though to be sure the four Court of Appeals opinions have uniformly rejected Secretary's reading), but even more significantly any quality of crystal clarity is uniformly recognized as totally absent from the Medicaid and Medicare statutes (thus even one of the cases relied on by appellees, *Kozlowski,* 42 F.3d at 1450, has pungently—and accurately—characterized the provisions detailing Medicaid and Medicare financing as "among the most completely impenetrable texts within human experience").

Section 1396a(n) is a superb example of the baffling nature of the statute. It has shown itself to be particularly resistant to a single simple interpretation, and hence particularly in need of clarification. While one battle has raged (with mixed results) over whether to accept Secretary's construction of the provision, even the courts that have rejected Secretary's approach have not expressed a single construction of the statute (compare *Kozlowski,* 42 F.3d at 1454, reading Section 1396a(n) to allow a state to exercise the option to pay more for a QMB than for a dual-eligible person; *Perales,* 954 F.2d at 859, stating "it appears that the reason that section a(n) authorizes

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title, rather than merely resolving an ambiguity, parallels the provision in Act § 4714(c) that specifically makes the statute applicable to pre-Act services involved in pending litigation.

payment beyond the Medicare amount, when it is required by another section, is to clarify that the Medicaid Act does not prohibit a provider from accepting more than the "Medicaid rate"; and *Snider*, 29 F.3d at 895, holding that Section 1396a(n) "authorizes the states to deviate from their schedules or payment methods with respect to QMB Part B cost-sharing payments, thus carving out an exception to the general requirement to comply with the Medicaid fee schedules or payment methods"). Only *Haynes*, 36 F.3d at 1076, by following the interpretation established in *Snider*, avoids the spectre of four Courts of Appeals reaching the same result for four (rather than three) different reasons. Congress noted the existing confusion when it made the statement (really an understatement) that the amount that states were required to pay on behalf of QMBs was "the subject of some controversy" (H. Conf. Rep. No. 105-217, 143 Cong. Rec. H6252 (daily ed. July 29, 1997)).

Given the extraordinary difficulty that the courts have found in divining the intent of the original Congress, a decision by the current Congress to intervene by expressly clarifying the meaning of Section 1396a(n) is worthy of real deference. Appellees' arguments that Act § 4714 is new law, despite Congress' unambiguous title for that section, cannot override that deference, because those arguments incorrectly presume a clearly established meaning for Section 1396(n)—something that simply did not exist before Act § 4714 was adopted.

We therefore honor Congress' "clarification" label and accept Act § 4714's provisions as a statement of what Section 1396a(n) has meant all along. That moots all of appellees' constitutional objections to the new legislation, because those objections rest entirely on the assertedly retroactive, rather than declaratory, nature of Act § 4714. But it is worth adding that we have, en route to our decision, carefully explored the litigants' arguments both as to the pre-Act version of Section 1396a(n) and

as to the constitutional issues raised by appellees if Act § 4714 were to be viewed as a retroactive change in, rather than a declaratory clarification of, the prior law—questions implicating the separation of powers, the Contract Clause and the Due Process Clause. And that exploration, which necessitated an effort on our part to parse the intricate and complex provisions of the pre-Act legislation, has only deepened our conviction that Congress' stated intention of clarifying that pre-existing law should be credited.

That leaves only one tag end for discussion, a statutory claim raised by the plaintiff Association in No. 96-55208 ("Beverly") that is unique to it as a provider of inpatient medical services to QMBs under Medicare Part A. Beverly argues in its supplemental brief that Medi-Cal's methodology for reimbursing hospitals for their Medicare expenses under Part A is not legal under either Beverly's or Secretary's interpretation of Act § 4714 (a)(2). Beverly urges this Court to affirm the district court's ruling below on that ground (under the familiar principle, as repeated in *Herring v. FDIC*, 82 F.3d 282, 284 (9th Cir. 1995), that an appellate court may uphold a ruling on any basis that the record supports, even if it was not considered by the lower court).

But before an appellate court will consider such an issue, ordinarily the argument must have been raised sufficiently for the trial court to rule on it (*A-1 Ambulance Serv. v. County of Monterey*, 90 F.3d 333, 338 (9th Cir.1996), citing *In re E.R. Fegert Inc.*, 887 F.2d 955, 957 (9th Cir.1989)). In this instance Beverly initially cited a single excerpt from the trial court record that it said had raised the statutory issue about Medi-Cal's Medicare Part A reimbursement policies. But post-argument its counsel has clarified its position as presenting a different assertion: that its current argument could not have been made below because it arose only as a result of standards set forth in the later-enacted Section 4714 (a)(1), now codified as Section 1396a(n)(2).

We need not resolve that newly-raised contention, nor does it call for a remand rather than a reversal. Any claim that California is violating the new federal statute—something that is necessarily not encompassed within the scope of the record as it was presented to the trial court and is thus not on review in the appeal before us—really represents the basis for a new lawsuit. Any such claim would call for the generation of a new record, against which a trial court could determine in the first instance whether there is anything to the contention that Act § 4714's clarification of the prior law somehow renders the Medi-Cal reimbursement methodology for hospitals under Medicare Part A invalid. And in that respect the trial court would also have to determine whether despite the existence of the new enactment, Beverly's argument on that score is one that it could perhaps have raised the first time around, so that it might be held to have forfeited the argument by virtue of its not having done so in this original litigation.

Conclusion

For the reasons that we have stated here at some length, we conclude that Act § 4714 is a clarification of the original intent of Congress when it passed Section 1396a(n). That being the case, the district courts' orders granting summary judgment in favor of each appellee are REVERSED. As a final point, we note that Director Belshe has not requested a remand in order to seek to recoup any excessive payments made pursuant to the district court's orders. We indicate no view as to her right to obtain any such relief.

[Filed Mar. 3, 1998]

NOT FOR PUBLICATION

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

No. 96-55208

D.C. No. CV 95-4053 JSL

BEVERLY COMMUNITY HOSPITAL ASS'N
Plaintiff-Appellee,

v.

S. KIMBERLY BELSHE, Director of the California Dep't of Human Services,
Defendant-Appellant.

Nos. 96-56249
96-56485
96-56648
97-55022

D.C. Nos. CV-96-2322-JSL
CV-96-3033-JSL

CALIFORNIA AMBULANCE ASS'N,
CALIFORNIA MEDICAL ASS'N, *et al.*,
Plaintiffs-Appellees,

v.

S. KIMBERLY BELSHE, Director of the California Dep't of Human Services, and DONNA E. SHALALA, Secretary, United States Dep't of Health and Human Services,
Defendants-Appellants.

Nos. 96-56699
96-56745
97-55713
97-55220

D.C. No. CV-96-5564 JSL

RICHARD GILMORE, *et al.*,
Plaintiffs-Appellees,
v.
S. KIMBERLY BELSHE, Director of the California Dep't of Human Services, and DONNA E. SHALALA, Secretary, United States Dep't of Health and Human Services,
Defendants-Appellants.

ORDER

Before: REINHARDT and TASHIMA Circuit Judges, and SHADUR, District Judge.**

The panel has voted to deny the petitions for rehearing and to reject the suggestions for rehearing en banc. The full court has been advised of the suggestion for rehearing en banc, and no judge of the court has requested a vote on the suggestions for rehearing en banc. Fed. R. App. P. 35(b).

The petitions for rehearing are denied and the suggestions for rehearing en banc are rejected.

** The Honorable Milton I. Shadur, Senior United States District Judge for the Northern District of Illinois, sitting by designation.

[Filed Dec. 16, 1996]

UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA

Case No. CV 96-5564 JSL

RICHARD GILMORE, M.D. and PRATAP SARAF, M.D., individually, and on behalf of all those similarly situated,
Plaintiffs,

v.

DONNA SHALALA, Secretary of the United States Department of Health and Human Services, and S. KIMBERLY BELSHE, Director of the California Department of Health Services,
Defendants.

FINAL JUDGMENT

Having reviewed the papers filed in connection with this matter, and being fully appraised of the relevant facts and law, on the Court's own motion, the Court hereby finds and determines as follows:

A. This Court has granted judgment in favor of the plaintiffs in *California Medical Association v. Donna Shalala, et al.*, Case No. CV 96-3033; *California Ambulance Association v. Donna Shalala, et al.*, Case No. CV 96-2322; and *Beverly Community Hospital Association v. Belshe*, Case No. CV 95-4053, all of which raise similar or identical issues of fact and law.

B. Under the Medicare and Medicaid Acts, including but not limited to 42 U.S.C. § 1396a(a)(10)(E):

1. Plaintiffs are entitled to compensation for medical and other health services rendered to QMBs at 80% of

the Medicare allowable rate plus the full Medicare Part B cost-sharing amount;

2. Plaintiffs' compensation for medical and other health services rendered to QMBs is not limited by the Medi-Cal reimbursement rate for such services; and

3. The Medi-Cal Program as administered by defendant Belshe and approved by defendant Shalala, California Welfare & Institutions Code Section 14109.5, and the Medi-Cal Program's implementing bulletins and regulations, to the extent that they reduce or eliminate payment or reimbursement by Medi-Cal of the full Medicare Part B cost-sharing amounts for medical and other health services furnished to QMBs, violate federal law and Plaintiffs' rights under 42 U.S.C. § 1983.

Based on the foregoing findings and for good cause appearing therefor,

IT IS HEREBY ORDERED, ADJUDGED AND DECREED that judgment be, and hereby is, entered in favor of the named Plaintiffs and against Defendants as follows:

1. Defendants and their successors, officers, agents, servants and employees are permanently enjoined from approving, allowing to be implemented, and enforcing the Medi-Cal Program, including California Welfare & Institutions Code Section 14109.5 and implementing bulletins and regulations, to the extent that they violate federal law by (1) preventing Plaintiffs from receiving compensation for medical and other health services provided to QMBs at the rates appropriate under federal law, and (2) reducing or eliminating payment or reimbursement by Medi-Cal of the full Medicare Part B cost-sharing amount for medical and other health services provided to QMBs.

2. Defendants shall pay Plaintiffs' attorneys' fees in a sum to be determined after determination of any appeal by Defendants or the time for defendants to file an appeal has expired.

DATE: 12/16/96

/s/ J. Spencer Letts
HONORABLE J. SPENCER LETTS
United States District Judge

Submitted by:

GREENBERG, GLUSKER, FIELDS,
CLAMAN & MACHTINGER LLP

By: /s/ Michael A. Greene
MICHAEL A. GREENE
Attorneys for Plaintiffs
Richard Gilmore, M.D. and
Pratap Saraf, M.D.

[Filed Sep. 24, 1996]

UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA

CV96-5564 JSL

RICHARD GILMORE, M.D. and PRATAP SARAF, M.D.
Plaintiffs,

v.

DONNA SHALALA, *et al.*,
Defendants.

JUDGMENT

Having reviewed the papers filed in connection with this matter, having heard oral argument, and being fully apprised of the relevant facts and law, on the Court's own motion IT IS HEREBY ORDERED AND ADJUDGED that judgment be entered for the plaintiffs based on the complaint. This case appears to raise no new issues of fact and law than those already determined by the Court in *California Ambulance Association v. Donna Shalala, et al.*, CV96-2322; *California Medical Association v. Donna Shalala et al.*, CV96-3033; and *Beverly Community Hospital Association v. Belshe*, CV 95-4053. If either party feels that this action does present a question of law and fact not addressed in the Court's three earlier rulings, they are granted leave to file a motion to reconsider. The Court requests that the plaintiffs submit a final order and judgment. By granting judgment for the plaintiffs on the basis of the pleadings, the Court does not expect that there will be motion for attorney fees. The Court may amend or amplify this order with a more specific statement of the grounds for its decision.

IT IS SO ORDERED.

Dated: 9/24/96

/s/ J. Spencer Letts
J. SPENCER LETTS
United States District Judge

CONSTITUTIONAL PROVISIONS

U.S. Const., art. I, § 10 (first paragraph)

No State shall enter into any Treaty, Alliance, or Confederation; grant letters of Marque and Reprisal; coin Money; emit Bills of Credit; make any Thing but gold and silver Coin a Tender in Payment of Debts; pass any Bill of Attainder, ex post facto Law, or Law impairing the Obligation of Contracts, or grant any Title of Nobility.

U.S. Const., art. III, § 1. Judicial Power, Tenure and Compensation

The judicial Power of the United States, shall be vested in one Supreme Court, and in such inferior Courts as the Congress may from time to time ordain and establish. The Judges, both of the supreme and inferior Courts, shall hold their Offices during good Behaviour, and shall, at stated Times, receive for their Services, a Compensation, which shall not be diminished during their Continuance in Office.

U.S. Const., amend. V.

No person shall be held to answer for a capital, or otherwise infamous crime, unless on a presentment or indictment of a Grand Jury, except in cases arising in the land or naval forces, or in the Militia, when in actual service in time of War or public danger; nor shall any person be subject for the same offence to be twice put in jeopardy of life or limb; nor shall be compelled in any criminal case to be a witness against himself, nor be deprived of life, liberty, or property, without due process of law; nor shall private property be taken for public use, without just compensation.

STATUTES

Amendments enacted pursuant to § 4714 of the Balanced Budget Act of 1997 are set forth in [bracketed] italics.

42 U.S.C. § 1395l. Payment of benefits

(a) Amounts

Except as provided in section 1395mm of this title and subject to the succeeding provisions of this section, there shall be paid from the Federal Supplementary Medical Insurance Trust Fund, in the case of an individual who is covered under the insurance program established by this part and incurs expenses for services with respect to which benefits are payable under this part, amounts equal to—

(1) in the case of services described in section 1395k (a)(1) of this title—80 percent of the reasonable charges for the services; except that . . . (N) with respect to expenses incurred for physicians' services (as defined in section 1395w-4(j)(3) *of* this title, the amounts paid shall be 80 percent of the payment basis determined under section 1395w-4(a)(1) of this title, . . .

42 U.S.C. § 1395u. Use of carriers for administration of benefits

(h) Participating physician or supplier; agreement with Secretary; publication of directories; availability; inclusion of program in explanation of benefits; payment of claims on an assignment related basis

(1) Any physician or supplier may voluntarily enter into an agreement with the Secretary to become a participating physician or supplier. For purposes of this section, the term "participating physician or supplier" means a physician or supplier (excluding any provider of services) who, before the beginning of any year beginning with 1984,

enters into an agreement with the Secretary which provides that such physician or supplier will accept payment under this part on an assignment-related basis for all items and services furnished to individuals enrolled under this part during such year. . . .

42 U.S.C. § 1395w-4. Payment for physicians' services

(a) Payment based on fee schedule

(1) In general

Effective for all physicians' services (as defined in subsection (j)(3) of this section) furnished under this part during a year (beginning with 1992) for which payment is otherwise made on the basis of a reasonable charge or on the basis of a fee schedule under section 1395m(b) of this title, payment under this part instead shall be based on the lesser of—

(A) the actual charge for the service, or

(B) subject to the succeeding provisions of this subsection, the amount determined under the fee schedule established under subsection (b) of this section for services furnished during that year (in this subsection referred to as the "fee schedule amount").

(g) Limitation on beneficiary liability

(3) Limitation on charges for medicare beneficiaries eligible for medicaid benefits

(A) In general

Payment for physicians' services furnished on or after April 1, 1990, to an individual who is enrolled under this part and eligible for any medical assistance (including as a qualified medicare beneficiary, as defined in section 1396d(p)(1) of this title) with respect to such services under a State plan approved under subchapter XIX of this chapter may only be made on an assignment-related basis [*and the provisions of sec-*

tion 1396a(n)(3)(A) apply to further limit permissible charges under this section].

42 U.S.C. § 1396a. State plans for medical assistance

(a) Contents

A state plan for medical ascistance must—

(10) provide—

(E)(i) for making medical assistance available for medicare cost sharing (as defined in section 1396d(p)(3) of this title) for qualified medicare beneficiaries described in section 1396d(p)(1) of this title; . . .

except that . . . (VIII) the medical assistance made available to a qualified medicare beneficiary described in section 1396d(p)(1) of this title who is only entitled to medical assistance because the individual is such a beneficiary shall be limited to medical assistance for medicare cost sharing (described in section 1396d(p)(3) of this title), subject to the provisions of subsection (n) of this section and 1396o(b) of this title,

(n) Payment amounts

[*(1)*] In the case of medical assistance furnished under this subchapter for medicare cost sharing respecting the furnishing of a service or item to a qualified medicare beneficiary, the State plan may provide payment in an amount with respect to the service or item that results in the sum of such payment amount and any amount of payment made under subchapter XVIII of this chapter with respect to the service or item exceeding the amount that is otherwise payable under the State plan for the item or service for eligible individuals who are not qualified medicare beneficiaries.

[*(2) In carrying out paragraph (1), a State is not required to provide any payment for any expenses incurred*

relating to payment for deductibles, coinsurance, or co-payments for medicare cost-sharing to the extent that payment under subchapter XVIII for services would exceed the payment amount that otherwise would be made under the State plan under this subchapter for such service if provided to an eligible recipient other than a medicare beneficiary.

(3) In the case in which a State's payment for medicare cost-sharing for a qualified medicare beneficiary with respect to an item or service is reduced or eliminated through the application of paragraph (2)—

(A) for purposes of applying any limitation under subchapter XVIII on the amount that the beneficiary may be billed or charged for the service, the amount of payment made under subchapter XVIII plus the amount of payment (if any) under the State plan shall be considered to be payment in full for the service;

(B) the beneficiary shall not have any legal liability to make payment to a provider or to an organization described in section 1396a(m)(1)(A) for the service; and

(C) any lawful sanction that may be imposed upon a provider or such an organization for excess charges under this subchapter or subchapter XVIII shall apply to the imposition of any charge imposed upon the individual in such case.

This paragraph shall not be construed as preventing payment of any medicare cost-sharing by a medicare supplemental policy or an employer retiree health plan on behalf of an individual.]

42 U.S.C. § 1396b. Payment to States

(b) Quarterly expenditures beginning after December 31, 1969

(1) Notwithstanding the preceding provisions of this section, the amounts determined under subsection (a)(1) of this section for any State for any quarter beginning

after December 31, 1969, shall not take into account any amounts expended as medical assistance with respect to individuals aged 65 and over and disabled individuals entitled to hospital insurance benefits under subchapter XVIII of this chapter which would not have been so expended if the individuals involved had been enrolled in the insurance program established by part B of subchapter XVIII of this chapter, other than amounts expended under provisions of the plan of such State required by section 1396a(a)(34) of this title.

42 U.S.C. § 1396c. Operation of State plans

If the Secretary, after reasonable notice and opportunity for hearing to the State agency administering or supervising the administration of the State plan approved under this subchapter, finds—

(1) that the plan has been so changed that it no longer complies with the provisions of section 1396a of this title; or

(2) that in the administration of the plan there is a failure to comply substantially with any such provisions;

the Secretary shall notify such State agency that further payments will not be made to the State (or, in his discretion, that payments will be limited to categories under or parts of the State plan not affected by such failure), until the Secretary is satisfied that there will no longer be any such failure to comply. Until he is so satisfied he shall make no further payments to such State (or shall limit payments to categories under or parts of the State plan not affected by such failure).

42 U.S.C. § 1396d. Definitions

For purposes of this subchapter—

(b) Federal medical assistance percentage; State percentage; Indian health care percentage

Subject to section 1396u-3 of this title, the term "Federal medical assistance percentage" for any State shall be

100 per centum less the the State percentage; and the State percentage shall be that percentage which bears the same ratio to 45 per centum as the square of the per capita income of such State bears to the square of the per capita income of the continental United States (including Alaska) and Hawaii; except that (1) the Federal medical assistance percentage shall in no case be less than 50 per centum or more than 83 per centum. . . .

(p) Qualified medicare beneficiary; medicare cost sharing

(1) The term "qualified medicare beneficiary" means an individual—

(A) who is entitled to hospital insurance benefits under part A of subchapter XVIII of this chapter (including an individual entitled to such benefits pursuant to an enrollment under section 1395i-2 of this title, but not including an individual entitled to such benefits only pursuant to an enrollment under section 1395i-2 of this title),

(B) whose income (as determined under section 1382a of this title for purposes of the supplemental security income program except as provided in paragraph (2)(D)) does not exceed an income level established by the State consistent with paragraph (2), and

(C) whose resources (as determined under section 1382a of this title for purposes of the supplemental security income program) do not exceed twice the maximum amount of resources that an individual may have and obtain benefits under that program.

(3) The term "medicare cost sharing" means [*(subject to section 1396a(n)(2) of this title)*] the following costs incurred with respect to a qualified medicare beneficiary, without regard to whether the costs incurred were for items or services for which medical assistance is otherwise available under the plan:

(A)(i) premiums under section 1395i-2 or 1395i-2a of this title, and

(ii) premiums under section 1395r of this title,

(B) Coinsurance under subchapter XVIII of this chapter (including coinsurance described in section 1395e of this title).

(C) Deductibles established under subchapter XVIII of this chapter (including those described in section 1395e and section 1395*l*(b) of this title).

(D) The difference between the amount that is paid under section 1395*l*(a) of this title and the amount that would be paid under such section if any reference to "80 percent" therein were deemed a reference to "100 percent".

Such term also may include, at the option of the State, premiums for enrollment of a qualified medicare beneficiary with an eligible organization under section 1395mm of this title.

REGULATIONS

42 C.F.R. § 400.202 Definitions specific to Medicare.

As used in connection with the Medicare program, unless the context indicates otherwise—

. . .

Payment on an assignment-related basis means payment for Part B services—

(1) To a physician or other supplier that accepts assignment from the beneficiary, in accordance with § 424.55 or § 424.56 of this chapter;

(4) For services furnished by a person or entity other than those specified in paragraphs (b)(1) through (b)(3) of this section, 80 percent of the reasonable charges or 80 percent of the amount computed on any other payment basis for the services.

42 C.F.R. § 424.55 Payment to the supplier.

(a) Medicare pays the supplier for covered services if the beneficiary (or the person authorized to request payment on the beneficiary's behalf) assigns the claim to the supplier and the supplier accepts assignment.

(b) In accepting assignment, the supplier agrees to the following:

(1) To accept, as the full charge for the service, the amount the carrier determines to be the reasonable charge.

(2) To limit charges to the beneficiary as follows:

(i) To collect nothing for those services for which Medicare pays 100 percent of the reasonable charge.

(ii) To collect only the amount of the unmet deductible, plus 20 percent of the difference between the reasonable charge and the unmet deductible for those services for which Medicare pays 80 percent of that difference.

105th Congress
1st Session

Report
105-217

HOUSE OF REPRESENTATIVES

BALANCED BUDGET ACT OF 1997

CONFERENCE REPORT
TO ACCOMPANY
H.R. 2015

* * * *

TITLE IV—MEDICARE, MEDICAID, AND CHILDREN'S HEALTH PROGRAMS
Subtitle H—Medicaid
Chapter 2—Flexibility In Payment of Providers

SEC. 4714. MEDICAID PAYMENT RATES FOR CERTAIN MEDICARE COST-SHARING.

(a) CLARIFICATION REGARDING STATE LIABILITY FOR MEDICARE COST-SHARING.—

(1) IN GENERAL.—Section 1902(n) (42 U.S.C. 1396a(n)) is amended—

(A) by inserting "(1)" after "(n)", and

(B) by adding at the end the following:

"(2) In carrying out paragraph (1), a State is not required to provide any payment for any expenses incurred relating to payment for deductibles, coinsurance, or copayments for medicare cost-sharing to the extent that payment under title XVIII for the service would exceed the payment amount that otherwise would be made under the State plan under this title for such service if provided to an eligible recipient other than a medicare beneficiary.

"(3) In the case in which a State's payment for medicare cost-sharing for a qualified medicare beneficiary with respect to an item or service is reduced or eliminated through the application of paragraph (2)—

"(A) for purposes of applying any limitation under title XVIII on the amount that the beneficiary may be billed or charged for the service, the amount of payment made under title XVIII plus the amount of payment (if any) under the State plan shall be considered to be payment in full for the service;

"(B) the beneficiary shall not have any legal liability to make payment to a provider or to an organization described in section 1903(m)(1)(A) for for the service; and

"(C) any lawful sanction that may be imposed upon a provider or such an organization for excess charges under this title or title XVIII shall apply to the imposition of any charge imposed upon the individual in such case.

This paragraph shall not be construed as preventing payment of any medicare cost-sharing by a medicare supplemental policy or an employer retiree health plan on behalf of an individual.".

(2) CONFORMING CLARIFICATION.—Section 1905 (p)(3) (42 U.S.C. 1396d(p)3)) is amended by inserting "(subject to section 1902(n)(2))" after "means".

(b) LIMITATION ON MEDICARE PROVIDERS.—

(1) PROVIDER AGREEMENTS.—Section 1866(a)(1)(A) (42 U.S.C. 1395cc(a)(1)(A)) is amended—

(A) by inserting "(i)" after "(A)", and

(B) by inserting before the comma at the end the following: ", and (ii) not to impose

any charge that is prohibited under section 1902(n)(3)".

(2) NONPARTICIPATING PROVIDERS.—Section 1848(g)(3)(A) (42 U.S.C. 1395w-4(g)(3)(A)) is amended by inserting before the period at the end the following: "and the provisions of section 1902 (n)(3)(A) apply to further limit permissible charges under this section".

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to payment for (and with respect to provider agreements with respect to) items and services furnished on or after the date of the enactment of this Act. The amendments made by subsection (a) shall also apply to payment by a State for items and services furnished before such date if such payment is the subject of a law suit that is based on the provisions of sections 1902(n) and 1905(p) of the Social Security Act and that is pending as of, or is initiated after, the date of the enactment of this Act.

* * * *

JOINT EXPLANATORY STATEMENT OF THE COMMITTEE OF CONFERENCE

The managers on the part of the House and the Senate at the conference on the disagreeing votes of the two Houses on the amendment of the Senate to the bill (H.R. 2015) to provide for reconcilation pursuant to sections 104 to 105 of the concurrent resolution on the budget for fiscal year 1997, submit the following joint statement to the House and the Senate in explanation of the effect of the action agreed upon by the managers and recommended in the accompanying conference report:

* * * *

MEDICAID PAYMENT RATES FOR CERTAIN MEDICARE COST-SHARING

Section 5712 of Senate amendment

CURRENT LAW

State Medicaid programs are required to pay Medicare cost-sharing charges for individuals who are beneficiaries under both Medicaid and Medicare, (dual eligibles) and for qualified Medicare beneficiaries (QMBs). QMBs are individuals who have incomes not over 100% of the poverty level and who meet specified resources standards.) The amount of required payment has been the subject of some controversy.

State Medicaid programs frequently have lower payment rates for services than the rates that would be paid under Medicare. Program guidelines permit states to pay either (1) the full Medicare deductible and coinsurance amounts or (2) cost-sharing charges only to the extent that the Medicare provider has not received the full Medicaid rate for an item or service. Some courts have forced state Medicaid programs to reimburse Medicare providers to the full Medicare allowable rates for services provided to QMBs and dually eligible individuals.

HOUSE BILL

No provision.

SENATE AMENDMENT

Clarifies that state Medicaid programs may limit Medicare cost-sharing to amounts that, with the Medicare payment, do not exceed what the state's Medicaid program would have paid for such service to a recipient who is not a QMB. Specifies that the Medicare payment plus the state's Medicaid payment will be considered payment in full and the QMB will not be liable for payment to a provider or managed care entity. Additionally, provides that any sanctions for excess charges that may be imposed on a provider

or managed care entity under Medicare may be imposed for making excess charges under Medicaid.

Applies to items and services furnished on or after the date of enactment. In the case of payment that is subject to a law suit pending as of the date of enactment, or initiated after the date of enactment, applies to items and services furnished before the date of enactment.

CONFERENCE AGREEMENT

The conference agreement includes the Senate amendment.

[LOGO]

June E. O'Neill
Director

CONGRESSIONAL BUDGET OFFICE
U.S. CONGRESS
Washington, D.C. 20515

August 12, 1997

Honorable Franklin D. Raines
Director
Office of Management and Budget
Washington, D.C. 20503

Dear Mr. Raines:

The Congressional Budget Office, after consulting with the Committees on the Budget of the House of Representatives and the Senate, provides the enclosed estimates of the effects of H.R. 2014 (Public Law 105-34), the Taxpayer Relief Act of 1997, and H.R. 2015 (Public Law 105-33), the Balanced Budget Act of 1997, on direct spending and receipts. These estimates are required by section 252 of the Balanced Budget and Emergency Deficit Control Act of 1985. H.R. 2014 and H.R. 2015 were cleared by the Congress on July 31 and signed by the President on August 5. Section 10213 of H.R. 2015 provides that these two laws are not counted for pay-as-you-go purposes.

On August 11 the President identified one provision of Public Law 105-33 and two provisions of Public Law 105-34 for cancellation under the terms of the Line Item Veto Act. CBO's estimates do not reflect the effects of the proposed cancellations.

Sincerely,

/s/ June E. O'Neill
JUNE E. O'NEILL

Enclosures

cc: Honorable John R. Kasich
Chairman, House Committee on the Budget

Honorable John M. Spratt, Jr.
Ranking Minority Member, House Committee on the Budget

Honorable Pete V. Domenici
Chairman, Senate Committee on the Budget

Honorable Frank R. Lautenberg
Ranking Minority Member, Senate Committee on the Budget

Honorable Bill Archer
Chairman, House Committee on Ways and Means

Honorable Charles B. Rangel
Ranking Minority Member, House Committee on Ways and Means

Honorable William V. Roth, Jr.
Chairman, Senate Committee on Finance

Honorable Daniel Patrick Moynihan
Ranking Minority Member, Senate Committee on Finance

BUDGETARY IMPLICATIONS OF THE BALANCED BUDGET ACT OF 1997

SUMMARY AND INTRODUCTION

As part of a plan to balance the federal budget by 2002, the 105th Congress enacted and President Clinton signed two major pieces of legislation: the Taxpayer Relief Act of 1997 (H.R. 2014/Public Law 105-34) and the Balanced Budget Act of 1997 (H.R. 2015/Public Law 105-33). The Balanced Budget Act achieves $127 billion in net deficit reduction over the 1998-2002 period. Gross savings of $160 billion comprise:

- $112 billion from slowing the growth of the Medicare program;
- $21 billion from auctioning licenses to use portions of the electromagnetic spectrum;
- $7 billion from changes to Medicaid;
- $5 billion from increasing excise taxes on cigarettes and other tobacco products; and
- $15 billion from other spending reductions and tax increases.

These savings are partly offset by additional spending of $33 billion:

- $20 billion for children's health insurance initiatives and
- $13 billion to mitigate the effects of last year's welfare reform law.

The act also extends the limits on discretionary spending and the pay-as-you-go procedures for direct spending and receipts, but these provisions do not directly alter federal outlays or revenues. The summary table provides estimates of the act's budgetary effects by title. The following pages give details by program and provision.

Table 4D.—Estimated Budgetary Impact of Subtitle H, Medicaid

(By fiscal year, in billions of dollars)	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	1998-2002 Total	1998-2007 Total
Medicaid rates for Medicare cost sharing for QMB and dually eligible beneficiaries												
Medicaid	-0.8	-0.9	-1.0	-1.1	-1.2	-1.3	-1.4	-1.5	-1.7	-1.8	-5.0	-12.6
Medicare Benefits	0.5	0.5	0.6	0.6	0.7	0.7	0.8	0.9	1.0	1.0	2.9	7.3

SOURCE: Congressional Budget Office

* * * *

Medicaid Rates as Payment in Full. In recent years, many states have been required by court decisions to pay full Medicare rates for cost sharing for QMBs and people dually eligible for Medicare and Medicaid. This provision overturns these decisions and gives states the option not to pay providers Medicare cost sharing amounts in excess of Medicaid rates. According to the Physician Payment Review Commission, Medicaid payment rates are on average about 73 percent of Medicare payment rates. Limiting payment rates to providers for QMBs and dual eligibles to the lower payment rates will generate about $5 billion in federal Medicaid savings. However, CBO assumes that about one-third of the combined federal and state savings will be offset by behavioral responses by providers in the Medicare program, increasing Medicare costs by about $2.9 billion. The net federal savings in the two programs will be about $2.1 billion.

* * * *

your

MEDICARE HANDBOOK

1997

[Logo]

HEALTH CARE FINANCING ADMINISTRATION

MEDICARE PART B COVERAGE

Medicare Part B pays for a wide range of medical services and supplies, but perhaps most important, it helps pay doctor bills.

The medically necessary services of a doctor are covered no matter where you receive them, whether at home, in the doctor's office, in a clinic, in a nursing home, or in a hospital.

Benefit Limits

Some Part B benefits have special requirements, and some are more strictly limited than others. Pap smears, for example, are generally covered only every 3 years, mammograms every 24 months, and therapeutic shoes once a year for people who have severe diabetic foot disease.

You can receive services from an independent, Medicare-approved physical or occupational therapist. But the maximum Medicare will pay for each type of therapy in 1997 is $720.

Durable Medical Equipment: Wheelchairs and other durable medical equipment are covered only when prescribed by a doctor for use at home and when provided by a supplier approved by Medicare. You can find out what equipment is covered, and whether a supplier is approved, by calling Medicare's durable medical equipment (DME) regional carrier for your area. A state-by-state listing of DME carriers begins on page 29.

Ambulance Services: The ambulance benefit is also strictly limited. Medicare will help pay for the service only if:

1. The ambulance, equipment, and personnel meet Medicare requirements, *and;*
2. Transportation in any other vehicle could endanger your health.

Coverage is generally restricted to transportation between your home and a hospital, your home and a skilled nursing facility, or a hospital and a skilled nursing facility.

What's Not Covered: Many medical services and items are not covered by Medicare. They include, but are not limited to, routine physicals, most dental care, dentures, routine foot care, hearing aids, and most prescription drugs. Eyeglasses are covered only if you need corrective lenses after a cataract operation.

What You Pay

When you use your Part B benefits, you are responsible for paying the first $100 of the charges approved by Medicare. This is called the Part B annual deductible.

After the deductible is met, Medicare pays 80 percent of the Medicare-approved amount for most services. You are resonsible for the remaining 20 percent. This is called Part B coinsurance.

Sometimes your share of the bill is more than 20 percent of the Medicare-approved amount. If you receive outpatient services at a hospital, you are responsible for paying 20 percent of whatever the hospital charges, not 20 percent of a Medicare-approved amount. For some outpatient mental health services, your share is 50 percent of the Medicare-approved amount.

Besides having to pay Medicare's deductibles and coinsurance, you are responsible for all charges for services and supplies you receive that are not covered by Medicare.

What Is Assignment?

Always ask your doctors and medical suppliers whether they accept assignment. If they do, they will accept the amount Medicare approves for a particular service or supply and will not charge you more than the deductible and 20 percent coinsurance. That can mean savings for you.

Here's how. Let's suppose you go to a doctor who accepts assignment and that you have already paid the $100 Part B deductible for the year. Let's also assume that the Medicare-approved amount for the service you receive is $100.

Medicare would pay 80 percent of the $100 approved amount, or $80. You would be responsible for the other 20 percent, or $20. Medicare would pay its share of the bill directly to the doctor after the doctor filed your claim. The doctor could ask you to pay the $20 immediately but could not ask for more.

Here's what could happen if the doctor did not accept assignment. The doctor could charge $115, which is the $100 Medicare-approved amount plus the extra 15 percent that doctors who do not accept assignment are permitted to charge.

Medicare would pay 80 percent of $100, or $80 and you would be responsible for the remaining $35. But for doctors who do not accept Medicare assignment, Medicare will pay only its share of the bill, and the doctor could ask you to pay the $115 immediately. Medicare would send you a check for $80 after the doctor filed your claim.

Limiting Charge: Be aware that federal law prohibits a doctor who does not accept assignment from charging more than 15 percent above Medicare's approved amount. Any overcharges must be refunded. The following states offer stricter guidelines on limiting charges: Connecticut, Massachusetts, Minnesota, New York, Ohio, Pennsylvania, Rhode Island, and Vermont. If you live in one of these states, check with your state's insurance counseling program for details. You will find the phone number in the resource directory at the back of this book.

Other Charge Limits: Doctors who do not accept assignment for elective surgery are required to give you a written estimate of your costs before the surgery if the total charge will be $500 or more. If you are not given a written esti-

mate, you are entitled to a refund of any amount you paid in excess of the Medicare-approved amount for the surgery performed.

Additionally, any doctor who does not participate in Medicare and who provides you with a service that he or she knows or has reason to believe Medicare will determine to be medically unnecessary must tell you that in writing before performing the service. This is because Medicare will not pay for services it judges to be medically unnecessary. If written notice is not given, and you did not know that Medicare would not pay, you cannot be held liable to pay for that service. However, if you did receive written notice and signed an agreement to pay for the service, you will be held liable to pay.

Participating Doctors and Suppliers: To avoid excess charges, go to doctors and medical suppliers who accept assignment. Some do on a case-by-case basis. Others sign agreements to accept assignment of all Medicare claims. They are called participating doctors and suppliers. You can get the names, addresses, and telehone numbers of participating doctors and suppliers by calling your Medicare carrier. You will find the phone number for your state's carrier in the resource directory of this book.

Part B Claims

Carriers are private insurance companies that contract with the federal government to process Medicare claims and make payments for services and supplies covered by Part B.

Every time you go to the doctor for a service covered by Medicare, the doctor is required by law to send the claim for payment to the carrier for the area where the service was provided. After processing your claim, the carrier usually will send you a notice about your benefits. It shows what was billed, the amount Medicare approved, and what you owe. It also tells you how to file an appeal if you disagree with a payment decision. Contact the

carrier with any questions about a Part B claim. The carrier's name and telephone number are printed on the benefit notice. A state-by-state listing of Medicare carriers begins on page 29.

If you get Medicare under the Railroad Retirement system, your claims are processed by the United Health Care office that serves your region. You can get the telephone number from any Railroad Retirement Board office.

Getting A Second Opinion

Sometimes your doctor may recommend surgery for the treatment of a medical problem. In some cases, surgery is unavoidable. But, there is increasing evidence that many conditions can be treated equally well without surgery. Because even minor surgery involves some risk, you may want to get the opinion of another doctor before making a decision.

Medicare pays the same way for a second opinion as it pays for other doctor services as long as you are seeking advice for the treatment of a medical condition covered by Medicare. If the first two opinions contradict each other, Medicare will help pay for a third opinion. You can ask your own doctor to refer you to another doctor for a second opinion. Or, you can call your Medicare carrier and ask for the names and phone numbers of doctors in your area who provide second opinions.

PROGRAMS THAT HELP LOW-INCOME BENEFICIARIES

If you are a Medicare beneficiary with a very low income and few assets, you might qualify for state assistance in paying your health care costs. There are two programs that can help. One is called the "Qualified Medicare Beneficiary" (QMB) program and the other is called the "Specified Low-Income Medicare Beneficiary" (SLMB) program.

The QMB program pays Medicare's premiums, deductibles, and coinsurance for entitled older and disabled people who are qualified for Medicare Part A. If you do not have Part A or do not know if you are entitled, check with your local Social Security office, or call 1-800-772-1213. The TTY/TDD number for the hearing and speech impaired is 1-800-325-0778.

To be entitled to QMB, your income must be at or below the national poverty level and your financial resources (bank accounts, stocks, bonds, etc.) cannot be more than $4,000 for one person, or $6,000 for a couple. Some property, including the home you live in, one car, burial plots, and life insurance are usually not counted as resources.

The QMB monthly income limits for 1997 in the United States, for all States except Alaska and Hawaii, are:

- $678 for an individual
- $905 for a couple.

For Alaska, the QMB limits are $843 for an individual and $1126 for a couple.

For Hawaii, the QMB limits are $776 for an individual and $1037 for a couple.

MEDICARE PARTICIPATING PHYSICIANS OR SUPPLIER AGREEMENT [EXCERPT]

Name(s) and Address of Participant *
(Please Type or Print)

Physician or Supplier
Identification code(s) *

The above named person or organization, called "the participant," hereby enters into an agreement with the Medicare program to accept assignment of the Medicare Part B payment for all services for which the participant is eligible to accept assignment under the Medicare law and regulations and which are furnished while this agreement is in effect.

1. Meaning of Assignment—For purposes of this agreement, accepting assignment of the Medicare Part B payment means requesting direct Part B payment from the Medicare program. Under an assignment, the approved charge, determined by the Medicare carrier, shall be the full charge for the service covered under Part B. The participant shall not collect from the beneficiary or other person or organization for covered services more than the applicable deductible and coinsurance.

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* List all names and identification codes under which the participant files claims with the carrier with whom this agreement is being filed.

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No. 97-1947, No. 97-1949, No. 97-2079

IN THE SUPREME COURT OF THE UNITED STATES

OCTOBER TERM, 1997

BEVERLY COMMUNITY HOSPITAL ASS'N, *Petitioner*,

v.

S. KIMBERLY BELSHÉ, Director of the California Dept. of Health Services, *Respondent*.

CALIFORNIA AMBULANCE ASS'N and CALIFORNIA MEDICAL ASS'N, et al., *Petitioners*,

v.

S. KIMBERLY BELSHÉ, Director of the California Dept. of Health Services, and DONNA E. SHALALA, Secretary, United States Dept. of Health and Human Services, *Respondents*.

RICHARD GILMORE, et al., *Petitioner*,

v.

S. KIMBERLY BELSHÉ, Director of the California Dept. of Health Services, and DONNA E. SHALALA, Secretary, United States Dept. of Health and Human Services, *Respondents*.

On Petition for Writ Of Certiorari To The United States Court of Appeals for the Ninth Circuit

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BRIEF IN OPPOSITION TO PETITIONS FOR WRITS OF CERTIORARI

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QUESTION PRESENTED

Is California's interpretation of 42 U.S.C. section 1396a(n) correct in light of the fact the Secretary of the Department of Health and Human Services shared that interpretation, that Congress ratified that interpretation by clarifying legislation and that the interpretation is consistent with the statutory scheme regarding qualified medicare beneficiaries?

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PREFACE

S. Kimberly Belshé, Director ("California") of the Department of Health Services of the State of California hereby files this Brief in Opposition to the petitions for writs of certiorari filed by the Petitioners in California Ambulance Ass'n and California Medical Ass'n v. S. Kimberly Belshé et al., No. 97-2079 (herein "Associations"), Richard Gilmore, M.D., et al. v. Donna E. Shalala, et al., No. 97-1949 (herein "Gilmore", and Beverly Community Hospital Ass'n, et al. v. S. Kimberly Belshé. No. 97-1947 (herein "Beverly"). The Secretary of the United States Department of Health And Human Services will be refereed to as the "Secretary."

INTRODUCTION

The brief in opposition filed by California to the petitions for writ of certiorari filed by the three Petitioners is combined because the statutes, cases and issues in question in these petitions are essentially identical. Therefore, no purpose would be served by filing separate, identical briefs in opposition to each petition.

California does not dispute the jurisdictional statements (California Ambulance Ass'n, p. 1, Gilmore, p. 1, Beverly, p. 1), the constitutional provisions and statutes involved, (California Ambulance Ass'n, p. 1, Gilmore, p. 1, Beverly, p. 1), set forth in each petition. California does not dispute the description by each petitioner of the sequence of events in the trial court and the Ninth Circuit. (Gilmore, p. 8-10, California Ambulance Ass'n, p. 8-10, Beverly, p. 2-5,) California does not agree with the questions presented by the Petitioners.

SUMMARY OF ARGUMENT

The petitions do not state any compelling reason under Rule 10 for this Court to grant certiorari. There is no conflict among the circuits because the two circuit decisions after the enactment of section 4714 reached the same result. California and the Secretary are correct in their interpretation of the role section 1396a(n) plays in the payment permitted the states to providers regarding crossover claims. It is not convincing to argue that Congress did not really "clarify" prior legislation because Congress did not narrowly make the clarification but did its best to put the issue at rest. This Court has a reasonable and venerable rule regarding the weight it gives to Congress's clarification of statutory policy, which was applied properly by both circuits and which does not need further elaboration, and which is not in conflict with any other maxim of statutory interpretation. Whatever life the Klein decision might have, this action is not the place to explore its vitality because Congress did not create a rule of decision that would bind the judiciary. Finally, in California no provider under Medicaid had a reasonable expectation that it would receive 100% of the amount it charged for the services it rendered to the beneficiaries of the Medicaid Program who are the subject of this action.

STATEMENT OF THE CASE

STATUTORY AND REGULATORY BACKGROUND

1. Medicaid/Medi-Cal.

The Medicaid Act, Title XIX of the Social Security Act, 42 U.S.C. 1396 et seq., was enacted by Congress in 1965. Medicaid is a need-based cooperative federal and

state cost sharing venture that enables each state "as far as practicable under the conditions in such State," to provide necessary medical assistance to families and individuals with insufficient income and resources. See, Pub. L. No. 89-97, 79 Stat. 286 (1965), as amended, 42 U.S.C. 1396 et seq. A state is not required to participate in the Medicaid program, but if it chooses to participate it must comply with the Medicaid Act and its implementing regulations. 42 U.S.C. 1396c.

Under Medicaid, each state has a fee schedule or methodology that establishes a rate for every item or service covered under the state's Medicaid plan. California's Medicaid rates are almost always less than the allowable charge for services under Medicare. Participating providers must accept the Medicaid payment, together with any nominal co-payment obligations, as payment in full for services and amounts covered under the state plan.

The methods, procedures and payment levels for Medicaid services must be under 42 U.S.C. § 1396a(30)(A):

> "as necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services available under the plan at least to the extent that such care and services are available to the general population in the geographic area."

Therefore, during the period covered by this litigation, the states were obligated to maintain Medicaid rates at a level sufficient to attract sufficient providers to

provide items and service to the relevant patient (including the QMB) population. The Petitioners (and Amicus) do not contend that the level of the Medicaid rates is inconsistent with section 1396a(30)(A).

Medicaid is the payer of last resort, which is to say that "other available resources must be used before Medicaid pays for the care of an individual enrolled in the Medicaid program." S. Rep. No. 146, 99th Cong., 2d Sess. 1, 312 (1986), reprinted in 1986 USCCAN 42, 279. See, 42 U.S.C. 1396a(a)(25). The Secretary's regulations require the states to reimburse a provider only to the extent that the state's Medicaid rate exceeds the third-party payment. 42 C.F.R. 433.139(b)(1). The Secretary views Medicare as a third party insurer under these regulations.

2. Medicare.

Enacted in 1965, Title XVIII of the Social Security Act is commonly known as the Medicare Act. See, Pub. L. No. 89-97, 79 Stat. 291 (1965), as amended, 42 U.S.C. 1395 et seq. Individuals who are at least 65 years of age or disabled (and meet certain other eligibility requirements) are automatically covered in Part A of the Medicare program, which provides reimbursement for inpatient hospital care and related post-hospital, home health and hospice care for aged and disabled beneficiaries. 42 U.S.C. 1395c-1395i-4 (1995). Under Part A, the federal government pays a health care provider's reasonable cost for covered services, less deductibles and coinsurance. Medicare beneficiaries who receive Part A services are responsible for paying "deductibles" (a fixed and limited amount of money toward the charge of hospital care) and "coinsurance" (a percentage of reasonable cost for each day of care after the first sixty

days). Some individuals also pay a premium. 42 U.S.C. § 1395e; 42 C.F.R. § 409.80. These are referred to herein as "Medicare cost-sharing amounts."

Part B is a voluntary insurance program pursuant to which eligible individuals may purchase supplementary insurance for hospital out-patient services, physician services, and other medical services not covered under Part A. 42 U.S.C. 1395j; 42 U.S.C. 1395l(a)(1); 42 U.S.C. 1395l(b).

Generally the federal government pays 80% of the allowable charges for Medicare beneficiaries who receive Part B services. The beneficiaries are responsible for paying deductibles (a fixed and limited amount), and coinsurance or copayments (a percentage of the reasonable value of the service). 42 U.S.C. § 1395e; 42 U.S.C. § 1396d(p)(3). The amounts beneficiaries are responsible for are referred to above and throughout - as with Part A - as "Medicare cost-sharing amounts."

3. The QMB Provisions.

A. The QMB Program.

Between 1967 and 1986, states were required to pay cost-sharing only on behalf of persons eligible for both programs. In 1986, Congress broadened the class of persons eligible for such coverage beyond these dual eligible. Pub.L. No. 99-509, §9403, 100 Stat. 2053-2056. The 1986 amendments provided that "at the option of a State" the State Plan could "provide for making medical assistance available for medicare cost-sharing" for "qualified medicare beneficiaries." *id.* §9403(a)(3), 100 Stat. 2053.[1] (42 U.S.C. § 1396(a)(10)(E)(i).)

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1. At the time, QMB's were defined as persons (1) who were eligible for Medicare Part A but not otherwise eligible for Medicaid,

The states' obligations with regard to this new category of individuals were addressed in two subsections of section 9403. Section 9403(c)(2) provided that "the medical assistance made available to a qualified medicare beneficiary * * * shall be limited to medical assistance for medicare cost-sharing * * * subject to the provisions of subsection (n) [of this section]." Pub. L. No. 99-509, § 9403(c), 100 Stat. 2054 (codified in clause (VIII) in the matter following 42 U.S.C. § 1396a(a)(10)(F)) (emphasis supplied). The new Section "n," -- Section 9403(e) of the Public Law, (codified at 42 U.S.C. 1396a(n)) -- was entitled "Payment Amounts." It specified that states "may" provide for payment of Medicare cost-sharing in an amount "that results in the sum of such payment amount and any amount of payment made under [Medicare] * * * exceeding the amount that is otherwise payable under the State [i.e. Medicaid] plan * * *." Id. § 9403(e), 100 Stat. 2055. Thus, Congress expressed its intention that states not be required, although they might choose, to pay coinsurance on behalf of QMBs in amounts that exceeded the charges "otherwise payable" under the state's approved Medicaid plan.

B. 1998: Expansion of the QMB Program

The 1986 amendments, allowing states to pay cost-sharing for pure QMBs, had a limited practical effect: By 1988, only one state had chosen to purchase Part B Medicare for pure QMBs. H.R. Rep. No. 100-105(II), 100th Cong., 2d Sess. 59 (1988), *reprinted in* 1988 U.S.C.C.A.N. 857, 882. It was in 1988 that Congress for

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(2) whose income did not exceed an amount set by the state but not more than 100% of the poverty line, and (3) whose resources did not exceed the Supplemental Security Income (SSI) program's maximum. *id.* §9403(b) (42 U.S.C. § 1396d(p)(1).)

the first time mandated that states make medicare cost-sharing available to persons not otherwise eligible for Medicaid assistance, *i.e.*, to pure QMBs. Pub. L. No. 100-360, § 301(a)(1), 102 Stat. 748 (deleting "at the option of the State" from 42 U.S.C. § 1396a(a)(10)(E)(i)). In the same bill that Congress thus first mandated coverage of pure QMBs, it also expanded the pool of those eligible to be QMBs by doubling the amount of resources an individual could own without losing QMB status. *Id.* § 301(c)(2) (codified at 42 U.S.C. §1396d(p)(1)(C)).

When it imposed these new obligations on the states, Congress was aware of the prior, practical construction of the law that states had discretion whether to make cost sharing payments over the Medicaid fee amount:

> It is the understanding of the Committee that, with respect to dual Medicaid-Medicare eligible, some States pay the coinsurance even if the amount Medicare pays for the service is higher than the State Medicaid payment rate, while others do not. Under the Committee bill, States would not be required to pay the Medicare coinsurance in the case of a bill where the amount reimbursed by Medicare -- i.e., 80 percent of the reasonable charge -- exceeds the amount Medicaid would pay for the same item or service. However, if a State chooses to pay some or all of the co-insurance in this circumstance, Federal matching funds would, as under current law, be available for this cost.

H.R. Rep. No. 105(II), 100th Cong., 2d Sess. 61 (1988), *reprinted in* 1988 U.S.C.C.A.N. 857, 884.

Later in 1988, Congress changed the statutory definition of QMB to its current form, so that now it

includes both pure QMBs and dual eligible. Pub. L. No. 100-647, § 8434(a), 102 Stat. 3342, 3805. The accompanying House Conference Report explained that all Medicare-eligible persons with income and resources under the limits set by 42 U.S.C. 1396d(p)(1), are to be considered QMBs, "whether or not they are otherwise eligible for Medicaid." H.R. Conf. Rep. No. 1104, 100th Cong. 2d Sess. (1988), *reprinted in* 1988 U.S.C.C.A.N. 5048, 5344.

Finally, in 1989, Congress amended the Medicare Act to require that physicians treating QMBs accept assignment from Medicare, thereby precluding the billing of QMBs in excess of the fee schedule amount set by Medicaid. Pub. L. No. 101-239, § 6102, 103 Stat. 2106 (1989) (codified at 42 U.S.C. § 1395w-4(g)(3)(A)). In so doing, the House Report considered the current practices of the States, as approved by the Secretary, regarding Medicaid payment of coinsurance for QMBs and ratified this practice: "The Medicaid programs typically pay the Medicare coinsurance only to the extent that their payment, plus the Medicare payment, does not exceed what the Medicaid program would pay for the service in question * * *. The Committee bill * * * does not change the current policy regarding the amount which a Medicaid program must reimburse on such claims. H.R. Rep. No. 247, 101st Cong., 1st Sess. 364 (1989), reprinted in 1989 U.S.C.C.A.N. 1906, 2090 (emphasis added).

C. California's Implementation - Part A.

California's policy regarding reimbursement for providers of inpatient hospital services has been consistent since the enactment of California Welfare & Institutions Code § 14109.5 (effective January 1, 1982). However,

California's ability to effectuate the policy has been dependent on its Medicaid agency's, the Department of Health Services, ability to identify comparable services, which initially was not possible with hospital inpatient services. In 1992, section 14109.5 was amended to direct the Department to look toward Medicare itself for establishing rates for comparable hospital inpatient services, which the Department did pursuant to 42 U.S.C. § 1396a(a)(13)(A) ("the Boren Amendment") (now repealed, P.L. 105-33, 111 Stat. 251, sec. 4711 (1997)). When the Department had completed its required Boren Amendment analysis, it concluded that the amounts paid - as contrasted with the rates charged by the providers - by Medicare were reasonable and adequate reimbursement for the providers of inpatient hospital services to beneficiaries eligible for both Medicare and Medi-Cal. Accordingly, in 1994 the Department adopted the Medicare level of payment as its standard for reimbursement for services rendered to beneficiaries who are eligible for both Medicare and Medi-Cal.

D. California's Implementation - Part B.

Prior to January 1, 1982 California paid all deductibles and coinsurance costs on behalf of all enrollees under the Part B buy -in agreement. California's buy-in agreement was amended and approved by the Secretary, effective January 1, 1982, capping payment under the buy-in agreement to the maximum Medi-Cal (Medicaid) payment for the same service. (Samuel v. California Department of Health Services (N.D. Cal. 1983) 570 F.Supp. 566, as modified, 572 F.Supp. 273.)

Samuel held that under a buy-in agreement when California pays the Part B premiums the Medicare Part B coverage thereby becomes part of the Medi-Cal program's

scope of benefits. By holding that a health care provider that accepts a crossover beneficiary therefore must accept the patient as a Medi-Cal patient and by prohibiting providers from seeking further reimbursement from beneficiaries, the Court approved California's rate limitation for Part B services. (Samuel at p. 573.)

Hence, notwithstanding the expansion in the class of beneficiaries a state may include in its Medicaid state plan and buy-in agreement, Samuel holds that the program remains a Medicaid program pursuant to which a state may purchase some or all of the benefits provided through Medicare Part B (and by extension Part A) and is not required to reimburse providers at higher than the Medicaid rate.

E. The Litigation.

Once Congress passed the 1988 legislation, providers saw an opportunity to close the gap between what had always been a difference in payment and which had been approved in California under Samuel. Four Circuit Courts held, with dissents and with different views on the meaning of 1396a(n) and the policy motivating Congress in 1986 and 1988, that the providers were entitled to the higher Medicare rate. Rehabilitation Ass'n of Virginia v. Kozlowski, 42 F.3d 1444 (4th Cir.), (Niemeyer, J. dissenting), cert. denied, 116 S. Ct. 60 (1995) ("Kozlowski"); Haynes Ambulance Service v. Alabama, 36 F.3d 1074 (11th Cir. 1994) ("Haynes"); Pennsylvania Medical Soc'y v. Snider, 29 F.3d 886 (3d Cir. 1994) ("Snider"); New York City Health & Hosp. Corp. v. Perales, 954 F.2d 854 (2d Cir.), (Cardamone, J., dissenting) (cert. denied, 113 S. Ct. 461 (1992) ("Perales").

Later, in California, Judge Letts of the Central District agreed with the result of these decisions and entered judgment for the providers in the three cases in this action. In the Northern District, Judge Legge in Dameron Physicians Medical Group, Inc. v. Shalala, et al., 961 F.Supp. 1326 (N.D.Cal. 1997) reached the opposite conclusion:

> "In the absence of a clear answer in the statutory language, and in light of the United States Supreme Court's decision in Chevron and the Ninth Circuit's decision in Stephenson, this court must accept the defendants' interpretation of the statutes at issue. California may cap its payments at the Medi-Cal maximum levels." (Id. at 1333.)

The district courts in Snider, Haynes, and Perales had agreed also with the position taken by California and the Secretary.

Aside from the conflicting district court decisions, the various positions taken in the opinions justify the rule that deference should be given to the Secretary when the statutory scheme is unclear. In Snider, the court concluded that Congress' policy to make the crossover program mandatory was to force the states to expend a projected windfall on the elderly poor. (Id. at 902) Whether that intent was true, there was no legislative history Congress wanted the money to go to providers. In Perales, the court concluded Congress' policy was to prevent a two tiered reimbursement system for crossover beneficiaries. (Id. at 858-859.) However, the Perales court could only justify Congress' policy based upon tenuous inferences drawn from Congress' 1965 policy relating to the difference between private pay and

Medicare patients. (Ibid.) Haynes adopted Snider in its analysis. In Kozlowski, the court held, with Justice Niemeyer offering a different analysis, that the permissive language in section 1396a(n) is limited to the option the states possessed prior to 1988 to pay a higher Medicare benefits to "pure" QMBs than to dual eligible. The irony, in light of the Petitioners' argument that any attempt at clarification of policy by Congress should be ignored by the judiciary or given little weight, is that the circuits justified their interpretation of QMB reimbursement scheme based upon a search for the policy of Congress.

F. The Balanced Budget Act of 1997.

Given the litigation that developed regarding Congress's intention in the 1988 legislation, the welter of conflicting district and court of appeals decisions, and the conflict between the providers, on the one hand, and the states and Secretary on the other, Congress enacted section 4714 of the Balanced Budget Act of 1997 ("BBA") (P.L. 105-33, 111 Stat. 251, eff. August 5, 1997) entitled a "clarification regarding state liability for medicare cost-sharing." Congress amended section 42 U.S.C. section 1396a(n) to read as follows:

> (2) In carrying out paragraph (1), a State is not required to provide any payment for any expenses incurred related to payment for deductible, coinsurance, or copayments for medicare cost sharing to the extent that payment under title XVIII for the service would exceed the payment amount that otherwise would be made under the State plan under this title for such service if provided to an eligible recipient other than a medicare beneficiary.

Congress also provided that its clarification applied to existing litigation:

> (c) EFFECTIVE DATE.--The amendments made by this section shall apply to payment for (and with respect to provider agreements with respect to) items and services furnished on or after the date of the enactment of this Act. The amendments made by subsection (a) shall also apply to payment by a State for items and services furnished before such date if such payment is subject of a law suit that is based on the provisions of section 1902(n) and 1905(p) of the Social Security Act and that is pending as of, or is initiated after, the date of the enactment of this Act."

The Committee of Conference statement describes Congress understanding of pre-BBA law:

> "State Medicaid programs are required to pay Medicare cost-sharing charges for individuals who are beneficiaries under both Medicaid and Medicare, (dual eligible) and for qualified Medicare beneficiaries (QMBs). QMBs are individuals who have incomes not over 100% of the poverty level and who meet specified resources standards.) The amount of the required payment has been the subject of some controversy.State Medicaid Programs frequently have lower payment rates for services than the rates that would be paid under Medicare. Program guidelines permit states to pay either (1) the full Medicare deductible and coinsurance amounts or (2) cost-sharing charged only to the extent that the Medicare provider has not

received the full Medicaid rate for an item or service. Some courts have forced state medicare programs to reimburse Medicare provider to the full Medicare allowable rates for services provided to QMBs and dually eligible individuals." (See H. Conf. Rep. No 105-217, 105th Cong. 1st Sess. 870-870 reprinted in 1997 U.S.C.C.A.N 176, 491-492)

The report then concluded that the amendment:

"Clarifies that state Medicaid programs may limit Medicare cost-sharing to amounts that, with the Medicare payment, do not exceed what the state' Medicaid program would have paid for such service to a recipient who is not a QMB. Specifies that the Medicare payment plus the state' Medicaid payment will be considered payment in full and the QMB will not be liable for payment to a provider or managed care entity. Additionally provides that any sanction for excess charges that may be imposed on a provider or managed care entity under Medicare may be imposed for making excess charged under Medicaid. Applies to items and services furnished on or after the date of enactment. In the case of payment that is subject to a law suit that is pending as of the date of enactment, or initiated after the date of enactment, applies to items and services furnished before the date of enactment." (Ibid.)

G. Wisdom comes eventually - Beverly and Paramount decisions in favor of the Secretary and California.

The Ninth Circuit decided the case that is the subject of these petitions, Beverly Community Hospital Ass'n v. Belshe, 132 F.3d 1259 (9th Cir. 1997) and the Seventh Circuit decided Paramount Health Systems, Inc. v. Wright, 138 F.3d 706 (7th Cir. 1998). Both of these courts recognized that Congress' intent pre-BBA was unclear in relation to QMBs and that, giving deference to Congress' expression of clarification in section 4714, weighed the balance in favor of the interpretation taken by California and the Secretary.

In Beverly the court pointed out that "Section 1396a(n) is a superb example of the baffling nature of [the Medicaid and Medicare acts]." (Id. at 1266.) "It has shown itself to be particularly resistant to a single simple interpretation, and hence particularly in need of clarification." (Ibid.) In Paramount, although the court mused whether section 4714 really was a proper clarification, eventually it concluded the place of section 1396a(n) in Congress' scheme of reimbursement was sufficiently ambiguous to accept the interpretation of California and the Secretary, to wit:

> The Act is a hopeless muddle so far as [QMB] reimbursement is concerned, and while it seems to us that [the health providers have] the better interpretation, there is sufficient ambiguity to require us to defer to the government." (Id. at 711.)

Beverly and Paramount have been followed in McCreary, M.D. et al. v. Offner, et al., 1 F.Supp. 2d 32 (D.D.C. 1998) in which Judge Friedman of the District of Columbia District Court held:

> Whether one scrutinizes the clarifying claims of Section 4714 with a harsher gaze or not, one thing is clear: the law regarding state liability to pay for the health services provided to QMBs has never been crystal clear. Section 4714 has certainly provided clarification where it was needed. For this reason, the Court concludes that applying Section 4714 retroactively, as Congress directed, is not impermissible under the Constitution." (Emphasis supplied.) (Id at 49.)

The question now is whether this Court should accept the Petitioners' invitation to enter this "muddle" and resolve the issue.

REASONS FOR THIS COURT NOT TO GRANT THE PETITIONS FOR CERTIORARI

1. Although California and the Secretary are correct in their interpretation of section 1396n(a) in the context of QMBs and the evolution of their eligibility for Medicaid, arguably the provisons are ambiguous so the Secretary's interpretation should have been given Chevron deference.

In essence, the Petitioners are petitioning this court on their interpretation of section 1396a(n) as it existed pre-BBA. Whatever section 4714 did, it affirmed Congress' policy that states do not have to pay providers of Part A and B services to QMBs at the

Medicare rate. Accordingly, the Petitioners are contending for an interpretation of section 1396a(n) and a basic policy position about reimbursement that Congress is unwilling to support.

California is correct regarding its interpretation of its reimbursement duty under Medicaid. Medicaid is the payor of last resort. The statutory scheme is that all other sources of payment must be exhausted before the Medicaid program is available for payment. California has been consistent in this scheme. Until Judge Letts issued his order in 1996, California's Medicaid program did not reimburse providers more than the Medicaid rate for QMBs.

Part A was different but only because a difficulty existed in determining for hospital services what was the Medicaid rate in relation to the Medicare rate. Once that Medicaid rate was established in 1994 by California's Medicaid agency, Part A was applied consistently with reimbursement under Part B.

It is clear that Congress intended in 1988 to mandate the states to include QMBs as part of the Medicaid program. Few states had voluntarily joined - unquestionably owing to the financial burden that joinder would impose. In that light, without a clear expression of intent, it does not make sense for Congress to both mandate QMBs into the Medicaid program and to burden the states with additional financial costs - which they had been unwilling to assume - without a clear expression that the providers would benefit from this change in the law.

To the contrary, Congress left section 1396a(n) untouched in 1988 in order to preserve the states

flexibility in responding to this mandatory addition to the Medicaid program. As we pointed out above, Medicaid is a jointly funded federal-state program. As a joint spending program, "if Congress intends to impose a condition on the grant of federal moneys" to the states, "it must do so unambiguously." Pennhurst State School & Hosp. v. Halderman, 451 U.S. 1, 17 (1981) (citations omitted). Only if courts "insist[] that Congress speak with a clear voice" can the states "exercise their choice knowingly, cognizant of the consequences of their participation." (*Id.*) Although California believes Congress was clear in the past regarding its reimbursement duty to providers regarding section 1396a(n), at the minimum the provision is ambiguous and should not be interpreted against her under Pennhurst. In light of the Secretary's support for California's position, the Secretary's interpretation should be conclusive under Chevron U.S.A. Inc. v. National Resources Defense Council, Inc., 467 U.S. 837, 842-43 (1984).

The circuits could reject the Secretary's construction of the statute only if they were able to conclude that "Congress has directly spoken to the precise question at issue"; otherwise, "if the statute is silent or ambiguous with respect to the specific issue, the question for the court is whether the agency's answer is based on a permissible construction of the statute." Chevron, 467 U.S. at 842-43 (1984) (emphasis supplied) (footnote omitted). The Kozlowski majority acknowledged that the Medicaid and Medicare acts were "among the most impenetrable texts within human experience" and provide "dense reading of the most tortuous kind." 42 F.3d at 1444. In this "'complex and highly technical regulatory program,'" deference "is all

the more warranted." Thomas Jefferson University v. Shalala, 512 U.S. 704, 710 (1994) (citation omitted).

Section 1396a(a)(10)(E) of Title 42 provides that a state plan "must" make Medicaid funds available for medical cost-sharing on behalf of QMBs. "Cost-sharing" is separately defined as including Part A deductibles and coinsurance. 42 U.S.C. 1396d(p)(3). The Petitioners read Section 1396a(a)(10)(E) and Section 1396d(p)(3) together as making it mandatory on the states to pay 100% of all reasonable charges for QMBs.

Yet if the Petitioners are correct in their reading, Section 1396a(n) -- which is entitled "Payment Amounts" and permits (but does not require) states to make payments in excess of the Medicaid ceiling -- would be entirely unnecessary, even though this section was enacted at the very same time, and in the same piece of legislation that created Section 1396a(a)(10(E).

Apart from this anomaly, the Petitioners' statutory reading is flawed. It is argued that, having used the word "must" in §1396a(a)(10)(E), Congress made mandatory the obligation on states to pay cost-sharing. The statutory language the Petitioners rely upon, however, does not mandate payment of coinsurance and deductibles in full, as the Petitioners would have it. Section 1396d(p)(3) is not addressed to the subject of payment amounts. It merely states that in certain circumstances the state is obliged to pay premiums and deductibles and coinsurance, without specifying whether the costs are to be paid in full, or are subject to the standard Medicaid limits.

Because Section 1396a(a)(10)(E) does not specify the amount of money a state is obliged to pay as coinsurance for QMBs and dual eligible, the Court must look elsewhere in the statute. Finding the relevant section is not hard: 42 U.S.C. 1396a(n), which was enacted in the same piece of legislation as Section 1396a(a)(10)(E), is entitled "Payment Amounts," and gives the states leave to limit reimbursement of coinsurance and deductibles to the ceiling set by Medicaid -- or in the alternative to pay the full 100%, as the state wishes. Section 1396a(n) is the answer to the question posed by this lawsuit -- not Section 1396a(a)(10)(E).

The two provisions may be reconciled by reading Section 1396a(a)(10)(E) to require that funds be available for coinsurance and deductibles only to the extent that a Medicaid plan under Section 1396a(n) provides for payments in excess of Medicare payments.

2. No review is appropriate because the circuits are not in confict over the merits of this case.

Rule 10.1(a) sets forth that reason for granting a petition for certiorari might be "[w]hen a United States court of appeals has rendered a decision in conflict with the decision of another United States court of appeals on the same matter." The Petitioners' fundamental ground for requesting certiorari from this court is that there is a conflict among the circuits because the court of appeals in Paramount and Beverly reached different conclusions than Kozlowski, Haynes, Snider, and Perales. This argument is fallacious. When the four cases were decided, the courts did not have the clarification provided by Congress. We do not know

what result these courts would have reached with this additional factor in mind. In any event, the two circuits post-section 4714 are consistent in holding that, when taken with the clarification from Congress, the better decision was that section 1396a(n) did authorize the states to make payments to providers at an amount less than the Medicare payment rate. For this reason, there is no conflict which warrants review by this court.

3. The "clarification" cannot be considered bogus by the argument that Congress shold have made the "clarification" as the Petitioners would have Congress do it.

The Petitioners argue strongly that the "clarification" of Congressional intent is bogus - that the Paramount and Beverly courts should have found that Congress did not clarify the law - it substantially changed the law. It is clear that Congress did intend to clarify the law. The title to section 4714(a) states that the amendment is a "clarification." Section 4714(c) states that the amendment relates back to "items and services furnished before [the date of the enactment of this Act] if such payment is the subject of a law suit that is based on the provisions of sections 1902(n) and 1905(p) of the Social Security Act and that is pending as of, or is initiated after, the date of enactment of this Act." The House Committee report recognizes a reimbursement gap between what the states and Medicare pays and expressly states that section 4714 "clarifies that state Medicaid program may limit Medicare cost-sharing to amounts that, within the Medicare payment, do not exceed what the state's Medicaid program would have paid for such service to a recipient who is not a QMB."

The Petitioners press several arguments, in the face of Congress' explicit statement of clarification, to demonstrate that no clarification exists. They argue section 1396a(n) is unchanged in text as section 1396a(n)(1), that the cap is placed in a new subsection 1396a(n)(2), that three new provisions were enacted (i.e., that Medicare is "payment in full," that providers have no recourse against the beneficiaries, and that a third party may be liable for the payment gap) and that a clarification does not need an "effective" date. They also argue that it is probative that the "clarification" appears in a budget measure.

Petitioners' arguments beg the question. Congress' clarification tracks the interpretation California and the Secretary have taken regarding section 1396a(n). If Congress had not expressly stated it was clarifying the law, Petitioners' arguments might have some merit. Petitioners argument is that for Congress to have a true clarification it must legislate narrowly on the issue. Presumptively, if Congress had only enacted section 1396a(n)(2) and called it a clarification, Petitioners would have no complaint. The fact that Congress added provisions to make its original intent more workable or clear should not detract from its attempt to clarify the law.

The fact that section 4714 was enacted in a budget provision makes sense. The dispute is not over the coverage of benefits to poor people. The dispute is between providers, and the states and the federal government over the rates of reimbursement. The need for an effective date is reasonable. In the Snider, Perales, Haynes, and Kozlowski circuits, the providers are no longer to be paid at the Medicare rate. Congress wisely limited the impact of the clarification to

circuits which had pending lawsuits, not those in which the rights of the providers had become vested by virtue of a final judicial decision.

4. There is no "conflict" in this Court's decisions over the issue of the proper deference to be given a Congress' effort to clarify the law.

The Petitioners argue that a conflict exists between this Court's rule regarding the deference to be given Congressional enactments which purport to clarify the effect of prior law. In fact, that conflict does not exist or, if it does, it is hardly sufficient to justify this Court granting writs of certiorari to review these cases.

In Red Lion Broadcasting Co. v. FCC, 395 U.S. 381 (1968) this Court was confronted with a challenge by a licensee of the Federal Communications Commission to the "fairness doctrine." The FCC had interpreted the underlying statute by regulation which set forth the rule. Thirty years later Congress enacted a statement of the FCC rule under circumstances which the Court found to be a clarification of existing law. In such a case, this Court held:

> "Subsequent legislation declaring the intent of an earlier statute is entitled to great weight in statutory construction. And here this principle is given special force by the equally venerable principle that the construction of a statute by those charged with this execution should be followed unless there are compelling indications that it is wrong, especially when Congress has refused to alter the administration construction. Here, the

> Congress has not just kept its silence by refusing to overturn the administrative construction, but has ratified it with positive legislation. (Id. at 380-382 [footnotes omitted].)

This announcement of statutory construction in Red Lion Broadcasting fits the facts of these cases like a glove. The Secretary held to a long standing position that the states did not have to pay the full cost sharing amounts. Congress never altered the Secretary's interpretation. Later, Congress ratified that administrative construction with positive legislation by enacting section 4714. This Court in Red Lion Broadcasting pointed out that this principle of statutory construction was "venerable." (Id. at 381, n. 8.)

In Loving v. U.S., 517 U.S. 748, 116 S.Ct. 1737 (1996) this court repeated this "venerable" principle with approval but in a fact situation less applicable to the facts before this court.

The Petitioners create a false dilemma - that a conflict exists between two lines of authority of this Court and that only a resolution of that conflict in these cases can "clarify" the rule for subsequent cases. In order to advance that argument, the Petitioners contend that the line of cases exemplified by Public Employees Ret. System v. Betts, 492 U.S. 158 (1989) ("Betts") creates this conflict.

In Betts a disability retiree invoked a prohibition against age based discrimination under ERISA against a public employees retirement system which had insured her pursuant to a plan that pre-dated the discrimination provision. The critical question

was whether the plan was a "subterfuge" to avoid the prohibition. The retiree argued that certain statements by a house committee and by influential members of the Congress demonstrated its interpretation of "subterfuge" was appropriate.

> This Court disagreed, commenting: "We have observed on more than one occasion that the interpretation given by one Congress (or a committee or Member thereof) to an earlier statute is of little assistance in discerning the meaning of that statute. (citations omitted) (Id. at 168.)

In Betts and the others cited by Petitioners, Congress does not act as a whole in enacting a specific clarification of a statute. It makes sense that whether Congress is ambivalent whether a clarification is intended (Gwaltney v. Chesapeake Bay Foundation, 484 U.S. 49, 63 n.4 (1988); ; South Dakota v. Yankton Sioux Tribe -- U.S.--, 118 S.Ct. 789 (1998)) when a house committee or a member of Congress purports to speak about past Congressional intent (Mackey v. Lanier Collection Agency & Serv., 486 U.S. 825, 839-840), that "little" assistance is rendered. However, when Congress amends the substantive statute in such a fashion that it unequivocally signals that it is clarifying what has been a statute subject to different interpretations, it makes sense that this Court should invoke that "venerable" rule of statutory construction that the judiciary should give Congress' enactment "heavy weight."

In summary, then, there is really no conflict between the two principles.

5. Beverly and Paramount determined that the statutory role given to section 1396a(n) scheme was ambiguous and therefore weight should be given to the clarification by Congress.

As variation on the Petitioners' attempt to see a conflict where none exists, the Petitioners argue that the Ninth Circuit and the court in Paramount should have first done a detailed analysis of the statutory scheme to demonstrate there was an ambiguity for which clarification was necessary (e.g., "the Ninth Circuit's decision failed to independently determine for itself either the meaning and intent of the 1986 QMB amendments or whether § 4714...was in any way a tenable reading of the legislation." (California Ambulance Ass'n at 21.)

What the Ninth Circuit did was to point out that various opinions had used different approaches to the proper interpretation of the statute, that the proper intent was not clear, and that section 1396a(n) was a baffling statutory provision. The Petitioners can not concede it was unclear how section 1396a(n) fit into Congress' scheme for providing benefits to QMBs. Once they make that concession, Chevron kicks in and they are lost. In any event, the Court did conclude that section 4714 was a tenable clarification of section 1396a(n) and that deference should be shown to Congress.

In Paramount, the court reached the same conclusion. Both circuit opinions must be read as agreeing that section 1396a(n) is puzzling and therefore they fulfilled whatever responsibility the Petitioners would impose upon them regarding the interpretation of

section 1396a(n). Consequently, the Petitioners do not establish that the circuit opinions lacked any condition precedent to their deference to Congress' clarification of the controversy.

6. Klein is not a ground for review under the facts of these actions.

The Petitioners' citation of United States v. Klein, 80 U.S. 128 (1872) as a basis for review is mystifying. The argument appears to be that Klein is relevant because section 4714 represents a "rule of decision" passed by Congress designed to intrude into the judicial province. The Petitioners then raise the specter of an Article III dilemma allegedly represented by section 4714 so that this Court will have the "...opportunity to provide direction to the lower courts by clarifying the scope of Klein." (Beverly pet. at 23.)

The Beverly decision does not mention the issue. Judge Posner talks about it in Paramount but never thought it sufficiently important to resolve the issue. That is easy to see why. In Klein Congress specifically attempted to change the law retroactively to avoid a decision of this Court, intruding into the powers reserved to the judiciary by Article III. Section 4714 does not represent a rule of decision. It is a clarification of the law that was in dispute. The rule of this Court is that when Congress provides clarification the judiciary gives great or little weight to that clarification depending upon the circumstances of the clarification. The Klein issue is simply not presented by this action.

The Petitioners harp on the argument that Congress enacted section 4714 in order to "decide the

controversy in [its] favor," quoting United States v. Sioux Nation, 448 U.S. 371, 404, 100 S. Ct. 2716, 2735-36, 65 L.Ed 2d 844 (1980) as somehow relevant. Unquestionably, Congress had the authority to decide the controversy in its favor prospectively by amending the statute. (Plant v. Spendthrift Farm, Inc, 514 U.S. 211, 218 (1995). In that sense, Congress decided the controversy in favor of the Secretary and the state. In Sioux Nation, this Court discussed Klein but did not reach the Klein issue. Accordingly, it is hard to see how Sioux Nation adds anything to the Petitioners' case. Moreover, when Congress enacts a clarification, by the nature of a clarification Congress is attempting to direct the outcome in a fashion Congress perceives to be in its "favor."

Finally, Congress did not attempt to impose a rule of decision upon the four circuits in which the courts - erroneously - held against the Secretary. The scope of its clarification only went to those circuits in which no provider had received any vested right by a final judicial decision. Accordingly, Congress never crossed over the separation of powers between the legislature and the judiciary.

7. No provider in California was promised payment by the state for crossover claims at 100% of what Medicare Providers charge.

This issue can not be reached by this Court unless it resolves the underlying dispute whether section 1396a(n) - pre-BBA - provided flexibility to the states to set the payment levels for Part A and Part B services below the Medicare charge levels for crossover claims.

In any event, from the perspective of California, this issue is contrived.

The Petitioners argue that "It is fundamentally unfair and constitutionally infirm for Congress to tell a provider who has been promised $100 to provide a service, that after providing the service, the rate has been changed after the fact to $80." (California Ambulance Ass'n at 30.)[2] No provider in California was under the illusion that it was promised $100 and then paid $80. Under Samuel, since 1983 all providers were on notice that California paid the Medicaid level of payment - not the Medicare level of what the providers charged.

In California, the relationship between the providers and California is a contract. (California Medical Assn. v. Lackner, 117 Cal.App. 3d 552, 560 (1981).) In California, "A statute fixing government payments may amount to an offer which, when accepted by performance, culminates in a contract between the government and the offeree." (internal quotation marks removed.) (Ibid.) Under this theory, Lackner held that the regulations - which are authorized by statute - of the Department constituted an offer and the providers acceptance of that offer - by providing services - constituted an implied contract. (Id. at 561.)

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2. The amicus brief filed by the American Medical Association argues that 4714 is unconstitutional under Eastern Enterprises v. Apfel, -- U.S. --, 118 S.Ct. 2131 (1998), contending that "the law's effect depends solely upon the confiscation of [physician's vested rights to payment under the prior statutory scheme]." (AMA Brief at 11.) Yet, in California the reasonable expectation of physicians was that they would be paid at the Medicaid rate. Consequently, Eastern Enterprises - aside from the fact the facts of the case have no resemblance to those of this action - does not apply.

Welfare and Institutions Code section 14109.5 clearly expressed the California policy - offer if you will - to providers that they would not be reimbursed at the rates they charged pursuant to Medicare for crossover claims. Consequently, no California provider of Part A or Part B services was promised $100 as the Petitioners claim.

CONCLUSION

The petitions should be denied. "[Section 1396a(n)] has shown itself to be particularly resistant to a single simple interpretation, and hence particularly in need of clarification." Beverly at 1266).

Dated: August 28, 1998

Respectfully submitted,

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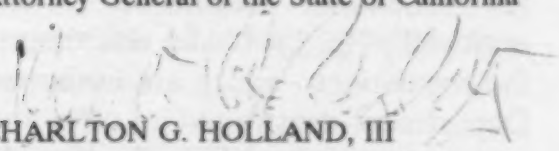

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APPENDIX A

§ 14109. Determination of medical needs; inclusion of cost of deductibles or cost sharing charge

In determining the medical needs of any person eligible under this chapter, and the amount of health care such person is entitled to receive, the department shall include the cost of any deductibles or, cost sharing or similar charge imposed in connection with benefits to which such person may be entitled under the federal program of health insurance for the aged and disabled, except that for those individuals 65 years of age or over, who prior to July 1, 1973, were ineligible under the federal program of health insurance for the aged, the director may include such costs.

§ 14109.5. (1982) Limitation on reimbursement rate notwithstanding inclusion of cost of deductibles or cost sharing charge; change orders, expeditious implementation

Notwithstanding the provisions of Section 14109, effective January 1, 1982, the reimbursement rate for costs specified in Section 14109 shall, to the extent feasible, not exceed the reimbursement rate for similar services established under this chapter.

The fiscal intermediary shall expedite the implementation of any change order resulting only from this section. The department shall provide sufficient funding for any such change order to enable the fiscal intermediary to implement such change order expeditiously and to not have to divert staff or other resources from existing contract tasks, including but not limited to those resources dedicated to the implementation of all other change orders.

(3) (3) (4)

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Nos. 97-1947, 97-1949 and 97-2079

In the Supreme Court of the United States

OCTOBER TERM, 1997

BEVERLY COMMUNITY HOSPITAL ASSOCIATION, DBA BEVERLY HOSPITAL, ET AL., PETITIONERS

v.

S. KIMBERLY BELSHÉ, DIRECTOR, CALIFORNIA DEPARTMENT OF HEALTH SERVICES

RICHARD GILMORE, M.D., ET AL., PETITIONERS

v.

DONNA E. SHALALA, ET AL.

CALIFORNIA AMBULANCE ASSOCIATION, ET AL., PETITIONERS

v.

DONNA E. SHALALA, ET AL.

ON PETITIONS FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

BRIEF FOR THE FEDERAL RESPONDENT IN OPPOSITION IN NOS. 97-1949 AND 97-2079 AND BRIEF FOR THE UNITED STATES AS AMICUS CURIAE SUPPORTING RESPONDENT IN NO. 97-1947

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QUESTION PRESENTED

Whether Section 4714 of the Balanced Budget Act of 1997, Pub. L. No. 105-33, 111 Stat. 509-511, clarifies the States' payment obligations to providers of medical services to qualified Medicare beneficiaries, set forth in the prior version of the Medicaid Act, 42 U.S.C. 1396a(n) (1994 & Supp. II 1996).

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In the Supreme Court of the United States

OCTOBER TERM, 1997

No. 97-1947

BEVERLY COMMUNITY HOSPITAL ASSOCIATION, DBA BEVERLY HOSPITAL, ET AL., PETITIONERS

v.

S. KIMBERLY BELSHÉ, DIRECTOR, CALIFORNIA DEPARTMENT OF HEALTH SERVICES

No. 97-1949

RICHARD GILMORE, M.D., ET AL., PETITIONERS

v.

DONNA E. SHALALA, ET AL.

No. 97-2079

CALIFORNIA AMBULANCE ASSOCIATION, ET AL., PETITIONERS

v.

DONNA E. SHALALA, ET AL.

ON PETITIONS FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

BRIEF FOR THE FEDERAL RESPONDENT IN OPPOSITION IN NOS. 97-1949 AND 97-2079 AND BRIEF FOR THE UNITED STATES AS AMICUS CURIAE SUPPORTING RESPONDENT IN NO. 97-1947

OPINIONS BELOW

This brief is submitted by the Secretary of Health and Human Services in opposition to three petitions for

a writ of certiorari that seek review of the same judgment of the United States Court of Appeals for Ninth Circuit. The Secretary was named as a defendant in No. 97-1949 and No. 97-2079, but participated only as *amicus curiae* in No. 97-1947. The opinion of the court of appeals (97-1947 Pet. App. 1a-23a) is reported at 132 F.3d 1259. The opinions of the district court (97-1947 Pet. App. 24a-29a; 97-1949 Pet. App. 23a-31a; 97-2079 Pet. App. 26-28) are unreported.

JURISDICTION

The judgment of the court of appeals was entered on December 2, 1997. 97-1947 Pet. App. 30a-32a. A petition for rehearing was denied on March 3, 1998. The petitions for a writ of certiorari were filed on June 1, 1998. The jurisdiction of this Court is invoked under 28 U.S.C. 1254(1).

STATEMENT

1. a. Medicare is a federal program that provides for medical coverage for individuals who are disabled or at least 65 years of age, and who meet certain other eligibility requirements. Those persons are automatically enrolled in Part A of the Medicare program, a federally funded hospital insurance program. See 42 U.S.C. 1395 *et seq.* (1994 & Supp. II 1996). A provider of medical services to beneficiaries under Medicare Part A receives a significant portion of its fee from the federal government, which pays the provider from the Federal Hospital Insurance Trust Fund established by 42 U.S.C. 1395i.[1] The beneficiary is responsible for coin-

[1] We use the term "provider" in this brief "in its colloquial sense rather than in its technical Medicare senses," as did the Seventh Circuit in the related case of *Paramount Health Systems,*

surance payments and deductible amounts. See 42 U.S.C. 1395e.

Persons who are covered by Medicare Part A (and certain other persons) may also purchase supplementary insurance for additional medical services under Part B of the Medicare program by paying a monthly premium to the Federal Supplementary Medical Insurance Trust Fund, which is established by 42 U.S.C. 1395t. A provider of medical services to beneficiaries under Medicare Part B receives a portion of its fee, typically 80% of the applicable fee schedule amount, from the Supplementary Medical Insurance Trust Fund. The beneficiaries of Part B services pay (in addition to premiums) coinsurance, copayments and deductible amounts. 42 U.S.C. 1395*l*(a)(1) and (b), 1395r.

b. The Medicaid program is a cooperative federal-state public assistance program that provides federal financial assistance (*i.e.*, federal matching funds) to States that elect to pay for medical services on behalf of certain needy individuals. See 42 U.S.C. 1396 *et seq.* (1994 & Supp. II 1996); *Harris* v. *McRae*, 448 U.S. 297, 301 (1980).[2] The Medicaid Act gives participating States discretion in setting the rates they will pay providers, within boundaries set by federal law. See 42 U.S.C. 1396a(a)(30). A participating State must submit a state plan, setting forth the fee schedule or methodology that the State will use in reimbursing providers, to the Secretary of Health and Human Services for ap-

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Inc. v. *Wright*, 138 F.3d 706, 706 (1998), petition for cert. pending, No. 97-2029.

[2] Federal financial participation is calculated according to a statutory formula that pays, at a minimum, 50% of the State's costs. 42 U.S.C. 1396b(a)(1), 1396d(b).

proval. See 42 U.S.C. 1396a(b). Providers generally must accept a State's payment for services covered under the Medicaid plan as payment in full, and may not seek to collect other than nominal payments for such services from the beneficiary or elsewhere. See 42 U.S.C. 1396*o*.

c. The Medicare and Medicaid Acts overlap in coverage for needy persons who are also elderly or disabled. Such individuals are often entitled to participate in Medicare Part A, but they may not be able to pay either the premiums needed to enroll in Medicare Part B or the coinsurance, copayments and deductibles for which they would be responsible under Parts A and B. To address that problem, Congress has required States participating in the Medicaid program to enter "buy-in" agreements with the Secretary of Health and Human Services. Under a buy-in agreement, the States use Medicaid funds to pay the Medicare Part B premiums on behalf of individuals who are eligible for both Medicare and Medicaid, and certain other persons who are eligible for Medicare but do not meet the general eligibility criteria for Medicaid coverage. See 42 U.S.C. 1395v, 1396d(a). As a result, the State's Medicaid program pays the Medicare premium, rather than the full medical expenses, of the elderly or disabled Medicaid-eligible persons, and these persons are then enrolled in the Medicare B program; the cost of their medical care thus is shifted in large part from the States' Medicaid programs to the federal government under Medicare.

Initially, the only persons eligible for this Medicare "cost-sharing" were those who met the qualifications for both Medicare and Medicaid services ("dual eligibles"). In 1986, Congress extended the class of persons eligible for the buy-in program to include individuals who have incomes below the federal poverty line but

who do not meet the income and assets qualifications for Medicaid eligibility. See Omnibus Budget Reconciliation Act of 1986 (OBRA), Pub. L. No. 99-509, § 9403, 100 Stat. 2053-2054. Members of this new class of individuals eligible for the buy-in program were called Qualified Medicare Beneficiaries, or "QMBs." See OBRA § 9403(b), 100 Stat. 2053. In 1988, Congress required States' Medicaid plans to buy-in to Medicare Part B for these individuals (as well as the "dual eligibles" who had been covered by buy-in agreements before 1986). Medicare Catastrophic Coverage Act of 1988, Pub. L. No. 100-360, § 301(a)(1), 102 Stat. 748. Congress also redefined the statutory term "qualified medicare beneficiary" to include both the former group of QMBs (a group often called "pure" QMBs) and dual eligibles. Technical and Miscellaneous Revenue Act of 1988, Pub. L. No. 100-647, § 8434, 102 Stat. 3805; see 42 U.S.C. 1396d(p)(1).

d. As noted above, Medicare Part B typically leaves individuals responsible for copayments, coinsurance, and deductible amounts. The elderly poor and disabled poor who are enrolled in Part B under the buy-in process (the QMBs) are often unable to meet such expenses. Congress has therefore required participating States' Medicaid plans to contribute towards those expenses on behalf of QMBs. See 42 U.S.C. 1396a(a)(10)(E)(i), 1396d(p)(3). The *amount* owed by the States to providers of medical services for those expenses is the subject of this dispute.

The Section of the Medicaid Act that governs the "contents" of state plans requires that a state plan for medical assistance must "provide * * * for making medical assistance [*i.e.*, Medicaid funds] available for medicare cost-sharing" for QMBs. 42 U.S.C. 1396a(a)(10)(E)(i). The Medicaid Act defines "medicare

cost-sharing" to include the specified premiums, coinsurance, copayments and deductibles owed under Medicare. 42 U.S.C. 1396d(p)(3).

Although Section 1396a(a)(10)(E)(i) thus requires States to make medical assistance available for Medicare cost-sharing for QMBs, that Section does not address the *amount* of cost-sharing to be paid by the States. A different Section, titled "Payment Amounts," addresses that issue. Before 1997, that Section provided:

> In the case of medical assistance furnished under this subchapter for medicare cost-sharing respecting the furnishing of a service or item to a qualified medicare beneficiary, the State plan *may provide payment* in an amount with respect to the service or item that results in the sum of such payment amount and any amount of payment made under subchapter XVIII of this chapter [*i.e.*, Medicare] with respect to the service or item *exceeding the amount that is otherwise payable under the State plan* for the item or service for eligible individuals who are not qualified medicare beneficiaries.

42 U.S.C. 1396a(n) (emphasis added).

The Secretary of Health and Human Services read Section 1396a(n) to permit States to limit their cost-sharing payments to the amount (if any) by which the State's Medicaid rate for the service provided exceeded the amount that Medicare has paid, and has approved state plans that impose such a cap.[3] In essence, the Secretary permitted the States to limit their payments to the amount that they would have paid for QMBs'

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[3] It is undisputed that States must pay Part B premiums in full.

medical services under the Medicaid program, had they not been enrolled in Medicare, less the federal contribution made under Medicare. Providers of medical services argued, however, that the Medicaid and Medicare statutes required the States to pay those expenses in full. Four courts of appeals rejected the Secretary's construction of the Medicaid Act and ruled that the Act required States to pay the cost sharing in full. See *Rehabilitation Ass'n of Virginia, Inc.* v. *Kozlowski*, 42 F.3d 1444 (4th Cir. 1994), cert. denied, 516 U.S. 811 (1995) (*Kozlowski*); *Haynes Ambulance Serv., Inc.* v. *State of Alabama*, 36 F.3d 1074 (11th Cir. 1994) (per curiam) (*Haynes*); *Pennsylvania Med. Soc'y* v. *Snider*, 29 F.3d 886 (3d Cir. 1994) (*Snider*); *New York City Health & Hosps. Corp.* v. *Perales*, 954 F.2d 854 (2d Cir.), cert. denied, 506 U.S. 972 (1992) (*Perales*).[4]

Although those appellate courts each rejected the Secretary's construction of Section 1396a(n), they disagreed among themselves as to the precise rationale for the result that they had reached, see 97-1947 Pet. App. 20a, there were dissents from two of the appellate decisions, see *Kozlowski*, 42 F.3d at 1462-1472 (Niemeyer, J., dissenting); *Perales*, 954 F.2d at 863-869 (Cardamone, J., dissenting), and two district courts upheld the Secretary's construction even after *Kozlowski*, the last of the appellate decisions, was issued. See *Dameron Physicians Med. Group* v. *Shalala*, 961 F. Supp. 1326

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[4] The relevant state authorities filed petitions for a writ of certiorari in *Kozlowski* and *Perales*. In the government's responses to the certiorari petitions in those cases, we argued that, although we believed that the courts of appeals' decisions were wrong, the absence of a conflict among the circuits counseled against further review. See 94-1912 Gov't Br. in Opp. 7-12 (July 1995); 92-315 Gov't Br. in Opp. 7-9 (Oct. 1992).

(N.D. Cal. 1997); *Kulkarni* v. *Leean*, No. 96-C-884-S, 1997 WL 527674 (W.D. Wis. June 23, 1997).

e. In 1997, Congress enacted Section 4714 of the Balanced Budget Act, which amended 42 U.S.C. 1396a(n). Section 4714(a) is titled "Clarification Regarding State Liability For Medicare Cost-Sharing." See Balanced Budget Act of 1997 (BBA or 1997 Act), § 4714(a), Pub. L. No. 105-33, 111 Stat. 509. It provides that, in carrying out its cost-sharing obligations under Section 1396a(n), "a State is not required to provide any payment for any expenses incurred relating to payment for deductibles, coinsurance, or copayments for medicare cost-sharing to the extent that" such payments would exceed "the payment amount that would otherwise be made under the State [Medicaid] plan." 42 U.S.C. 1396a(n)(1)(B). Section 4714(a) thus expressly continues in effect the Secretary's longstanding position under the applicable Medicaid provisions as they existed before the enactment of the 1997 Act. As its title states, Section 4714(a) was enacted to "[c]larif[y] that state Medicaid programs may limit Medicare cost-sharing to amounts that, with the Medicare payment, do not exceed what the state's Medicaid program would have paid for such service to a recipient who is not a QMB." H.R. Conf. Rep. No. 217, 105th Cong., 2d Sess. 870-871 (1997).

Congress also provided that the clarification in Section 4714(a) would apply, not only prospectively, but also to payments for items and services rendered before the effective date of the clarification, if such payments were the subject of any lawsuit pending as of, or initiated after, the date of enactment. See BBA § 4714(c), 111 Stat. 511; 97-1947 Pet. App. 38a. The amendment does not apply, however, to payments that were the subject of cases challenging the Secretary's

interpretation of the Medicaid Act prior to passage of the 1997 Act that had been litigated to final judgment.

2. a. Before the 1997 amendments were passed, petitioners, who provide medical services to QMBs in California, brought these actions to compel the California Medicaid program to pay cost-sharing for QMBs in full. Petitioners challenged California's policy, reflected in state regulations and in a state plan approved by the Secretary, of limiting cost-sharing payments to the amount (if any) by which the California Medicaid rate exceeds what Medicare pays. Petitioners argued, *inter alia*, that the Medicaid Act required the State to pay cost-sharing in full.

The same district judge presided in each case. The district court granted petitioners' motions for summary judgment, following the Second, Third, and Eleventh Circuit decisions that had rejected the Secretary's construction of the Medicaid Act, and also adopting the "similar reasoning" of the Fourth Circuit, except in part. See 97-2079 Pet. App. 26-28; see also 97-1947 Pet. App. 27a-29a; 97-1949 Pet. App. 20a-23a.

b. The Secretary appealed the district court's decisions. After briefing on appeal was complete, Congress enacted Section 4714 of the Balanced Budget Act of 1997. In supplemental briefing, petitioners urged that Section 4714 changed rather than clarified the prior payment rules, and that the retroactive application of the new payment rules was unconstitutional.[5] The court of appeals reversed. It held that Section 4714 clarified the law, and that it therefore has no retro-

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[5] Petitioners did not dispute that the new law could be applied prospectively. See 97-1947 Pet. App. 18a.

active effect that might be called into constitutional question. 97-1947 Pet. App. 1a-23a.[6]

The court emphasized that "Congress expressly (and formally) stated as its intention that the new provision in [BBA] § 4714 was a 'clarification' of the payment rules contained in Section 1396a(n). It has been established law since nearly the beginning of the republic * * * that congressional legislation that thus expresses the intent of an earlier statute must be accorded great weight." 97-1947 Pet. App. 18a. The court remarked that some of this Court's decisions have "question[ed] the competence of a later Congress to opine on the intended meaning of an earlier statute," but it observed that those decisions "involved attempts to use less formal types of subsequent legislative history, particularly Senate and House Committee Reports, to infer the meaning of prior enactments." *Ibid.* "By contrast, here Congress has formally declared [BBA] § 4714 to be a clarification of Section 1396a(n) in the title of the Act as well as in the Committee Reports." *Id.* at 19a.

The court rejected petitioners' argument that Section 4714(a) could not be a clarification of the law because it effected a substantial change in the law. That argument, the court held, failed to take account of the differences in rationales among the decisions construing Section 1396a(n); it also ignored the fact that "any quality of crystal clarity is uniformly recognized as

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[6] The court of appeals rejected petitioners' argument that Section 4714 does not apply to these cases because they were already on appeal when the Balanced Budget Act of 1997 was enacted, and therefore the cases were not "pending" within the meaning of Section 4714(c). See 97-1947 Pet. App. 16a-17a. That argument has not been renewed in this Court.

totally absent from the Medicaid and Medicare statutes," which have been characterized as "among the most completely impenetrable texts within human experience." 97-1947 Pet. App. 19a-20a. The court found Section 1396a(n) itself to be "a superb example of the baffling nature of the statute." *Id.* at 20a. "Given the extraordinary difficulty that the courts have found in divining the intent of the original Congress, a decision by the current Congress to intervene by expressly clarifying the meaning of Section 1396a(n) is worthy of real deference," and petitioners' arguments that the law changed rather than clarified the law "incorrectly presume a clearly established meaning for Section 1396a(n)—something that simply did not exist before [BBA] § 4714 was adopted." *Id.* at 20a-21a.

The court therefore "honor[ed]" Congress's express description of Section 4714(a) as a clarification of the law. 97-1947 Pet. App. 21a. That decision, observed the court, "moots all of [petitioners'] constitutional objections to the new legislation, because those objections rest entirely on the assertedly retroactive, rather than declaratory, nature of [BBA] § 4714." *Ibid.*

ARGUMENT

The court of appeals correctly concluded that Section 4714(a) of the Balanced Budget Act of 1997 clarified rather than changed existing law governing States' obligations under their Medicaid plans to pay for Medicare cost-sharing, and therefore raises no potential constitutional questions of retroactivity. That decision does not conflict with any decision of any other court of appeals, and it presents no issue of continuing importance. Furthermore, even if Section 4714(a) changed the law, petitioners' constitutional claims

would lack merit. Further review is therefore not warranted.

1. In enacting Section 4714(a), Congress ratified the Secretary's longstanding position that a State may limit its cost-sharing payments to the difference between the State's Medicaid rate and the amount that Medicare pays for a given service. Because the Secretary's construction of prior law was correct and reasonable, Section 4714 did not change the law and therefore raises no questions of retroactivity.

"The power of an administrative agency to administer a congressionally created * * * program necessarily requires the formulation of policy and the making of rules to fill any gap left, implicitly or explicitly, by Congress." *Morton* v. *Ruiz*, 415 U.S. 199, 231 (1974). Accordingly, as this Court held in *Chevron U.S.A. Inc.* v. *National Resources Defense Council, Inc.*, 467 U.S. 837 (1984), where Congress has not expressed its intention on a precise question at issue, courts should defer to a reasonable interpretation of the statute in question by the agency charged with administering the program under that statute. *Id.* at 844.

The Secretary's position on the extent of the States' cost-sharing obligations was reasonable. Section 1396a(a)(10)(E)(i) imposed upon the States the obligation to provide "for making medical assistance available for cost-sharing * * * for qualified medicare beneficiaries." That provision, however, did not specify any particular *amount* that States must make available for cost-sharing. Section 1396a(n), titled "Payment Amounts," did address the issue of amount, and provided that a State "may" pay cost-sharing even if the sum of the federal Medicare payment and the state payment exceeded the amount otherwise payable under

the state Medicaid plan to eligible individuals who are not QMBs. The Secretary reasonably construed Section 1396a(n) to permit, but not to require, States to pay cost-sharing in excess of the State's Medicaid rate. The Secretary's construction flowed naturally from the language of the Medicaid Act, since there was no other apparent reason for Congress to have provided in the Medicaid Act that a State "may" pay more cost-sharing than the difference between the State's Medicaid rate and the amount that Medicare pays.

Petitioners emphasize that three of the four courts of appeals that rejected the Secretary's construction of Section 1396a(n) read that provision as providing only that providers (or States) would not be penalized for accepting (or making) payments that, with the Medicare payment, exceeded the Medicaid rate. See *Perales*, 954 F.2d at 859; *Snider*, 29 F.3d at 895; *Haynes*, 36 F.3d at 1076. As the Seventh Circuit recently explained, however, those readings of the Medicaid Act are "undermined by the fact that if [as petitioners argue] * * * the statute *clearly* entitle[d] [petitioners] to reimbursement at Medicare rates, * * * the state [or provider] could hardly be penalized for such reimbursement. That would be penalizing it for complying with the statute." *Paramount Health Sys.* v. *Wright*, 138 F.3d 706, 709 (7th Cir. 1998), petition for cert. pending, No. 97-2029.[7] As Judge Niemeyer pointed out in his dissent in *Kozlowski*, "[i]t is utterly implausible * * * to believe that Congress would create a new section in the Act solely to acknowledge that it is permissible for states to do what

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[7] The petition pending in *Paramount* raises the same question as that presented here, and our response to that petition is being filed contemporaneously with this brief.

Congress *requires* them to do in other sections." 42 F.3d at 1469.

The Secretary's construction, moreover, comports with the purpose of the buy-in provisions, which is to relieve the States from the financial obligations that they would have to shoulder under their Medicaid plans if QMBs were not able to participate in the Medicare Part B program. Specifically, the Secretary's construction recognizes that, if the States did not buy QMBs into Medicare, the States would be required to pay for the medical care of at least those QMBs who are eligible for Medicaid, at whatever their Medicaid rates would allow. It is therefore reasonable to conclude that the States should not have to pay for medical services at a rate that is higher than the rate at which their own Medicaid plans would otherwise have required payment.

The legislative development of the provisions at issue further supports the reasonableness of the Secretary's construction. When Congress made buy-in coverage of all QMBs mandatory in 1988, the House Report accompanying the legislation specifically stated that States would not be required to make payments in excess of their Medicaid ceilings. See H.R. Rep. No. 105(II), 100th Cong., 2d Sess. 61 (1988). In 1989, Congress again amended the QMB provisions to "codif[y] the current practice with respect to dual eligibles and extend[] it to qualified Medicare beneficiaries." H.R. Rep. No. 247, 101st Cong., 1st Sess. 429 (1989). It did so, *inter alia*, by requiring physicians to accept assignments of claims from QMBs for the specific purpose of preventing physicians from exceeding the Medicaid ceilings by billing QMB patients directly for such additional amounts. *Ibid.*; see 42 U.S.C. 1395w-4(g)(3); Omnibus Budget Reconciliation Act of 1989, Pub. L. No.

101-239, § 6102(a), 103 Stat. 2169. Thus, Congress has treated QMBs principally as persons eligible for Medicaid benefits, but whose medical expenses are paid in large part by Medicare.

Even if the Medicaid Act is less than crystal clear on the extent of state Medicaid plans' obligations to pay for cost-sharing, it cannot be reasonably contended that the law was so clear and firmly settled against the Secretary's construction that Section 4714(a) must be viewed as a change in the law, despite Congress's express designation of it as a clarification. This Court, of course, had never considered the statutory question at issue. Although four circuits had rejected the Secretary's construction, they had not read the statutes in the same way, and neither the Seventh Circuit nor the Ninth Circuit—where the constitutional challenges to Section 4714(a) have been brought—addressed the statutory question. Two district courts had disagreed with the four circuits' construction of the Medicaid Act and had upheld the Secretary's position.

At a minimum, therefore, the Medicaid Act was "a hopeless muddle so far as [QMB] reimbursement [was] concerned." *Paramount*, 138 F.3d at 711; see also *Kozlowski*, 42 F.3d at 1450 (describing provisions governing Medicaid and Medicare financing as "among the most impenetrable texts within human experience"); 97-1947 Pet. App. 19a-20a (decision below; same). "[T]he fact that well-intentioned and intelligent experts at legal exegesis have arrived at three or four seemingly plausible readings of a particular text may be the best evidence that this interpretive puzzle has no definitive answer." *Kozlowski*, 42 F.3d at 1462-1463 (Niemeyer, J., dissenting). Under these circumstances, Congress's designation of Section 4714(a) as a clarifi-

cation, rather than a change, of the States' obligations under the Medicaid Act, deserves deference.

2. Petitioners urge the Court to grant certiorari to clarify how much weight should be given to a congressional interpretation of prior law, as reflected in a statutory amendment. Petitioners argue that there is tension in this Court's precedents addressing the issue. See 97-1947 Pet. 12-17; 97-1949 Pet. 18-21; 97-2079 Pet. 18-23. That issue is not presented in this case, however, because the Secretary reasonably construed the prior law to arrive at the result that Congress subsequently directed in Section 4714(a). Accordingly, the question of the weight owed to Congress's view, as expressed in Section 4714(a), that the new statute is a "clarification," is academic. At the least, this Court could not reject Congress's view that Section 4714 clarifies prior law without first analyzing the complex and now-superseded pre-1997 framework governing state payment of cost-sharing for QMBs, and determining whether the Secretary's construction of those provisions would have been owed deference under *Chevron*. That antecedent question of statutory interpretation, however, is of no continuing importance.

Moreover, the asserted tension in this Court's decisions is illusory. This Court has stated that express congressional declarations in *legislation* about the meaning of an earlier statute are given great weight, but that statements in "subsequent legislative history" such as committee reports about the meaning of earlier legislation are not. Compare, *e.g.*, *Loving* v. *United States*, 517 U.S. 748, 769-770 (1996) (legislation), and *Red Lion Broad. Co.* v. *FCC*, 395 U.S. 367, 380-381 (1969) (same); with, *e.g.*, *Public Employees Retirement Sys.* v. *Betts*, 492 U.S. 158, 167-168 (1989) (legislative history); *Gwaltney of Smithfield, Ltd.* v. *Chesapeake*

Bay Found., 484 U.S. 49, 63 n.4 (1987) (same); *Consumer Prod. Safety Comm'n* v. *GTE Sylvania*, 447 U.S. 102, 116-118 & n.13 (1980) (same); *United States* v. *Philadelphia Nat'l Bank*, 374 U.S. 321, 348-349 (1963) (same); and *United States* v. *United Mine Workers*, 330 U.S. 258, 281-282 (1947) (same).

In its *Paramount* decision, the Seventh Circuit identified two cases, *South Dakota* v. *Yankton Sioux Tribe*, 118 S. Ct. 789 (1998), and *Rainwater* v. *United States*, 356 U.S. 590 (1958), in which this Court declined to give weight to subsequent legislation in construing earlier enactments. See *Paramount*, 138 F.3d at 711. These cases are readily reconciled with the *Loving* line of authority. In *Yankton Sioux Tribe*, the subsequent legislative materials made contradictory statements about the effect of the prior law at issue, and the Court therefore declined to give those materials significant weight. See 118 S. Ct. at 804 (emphasizing that legislative record "reveals no consistent, or even dominant, approach to the territory in question, and it carries but little force in light of the strong textual and contemporaneous evidence of diminishment") (internal quotation marks omitted). Although the Court did state in that case that "the views of a subsequent Congress form a hazardous basis for inferring the intent of an earlier one," see *id.* at 803 (quoting *Philadelphia Nat'l Bank*, 374 U.S. at 348-349), it did not suggest that subsequent legislation should never be given heed in determining the scope of an earlier law passed by Congress.

Rainwater involved the applicability of the False Claims Act to civil claims against a wholly owned government corporation. It was argued in that case that Congress's amendment of the criminal (but not the civil) provisions of the Act in 1918, to cover "any corporation in which the United States of America is a

stockholder," suggested that the 1863 Congress that enacted the False Claims Act did not intend it to apply to any government corporations. The Court found the 1918 legislation not probative of the scope of the original Act because the amendment was evidently concerned with different kinds of corporations, in which the government might have an ownership interest, and not wholly owned government corporations. See *Rainwater*, 356 U.S. at 593-594. The Court did not suggest that subsequent legislation is *per se* irrelevant to the scope of an earlier statute; rather, it simply found the subsequent legislation in that case not probative.

This case is readily distinguishable from *Rainwater* and *Yankton*. In this case, Congress has unmistakably addressed the precise statutory question at hand in legislation. Petitioners therefore do not dispute that, prospectively at least, the amendments made by Section 4714(a) definitively define the scope of States' cost-sharing obligations. Under these circumstances, the lower court correctly concluded that Congress's clarification of Section 1396a(n) in 1997 deserved great deference in defining the earlier scope of that law.[8]

3. Petitioners argue that Section 4714 effects an unconstitutionally retroactive change in the law gov-

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[8] The Seventh Circuit expressed concern that the *Loving* line of cases would permit an unsuccessful litigant to obtain a "'clarifying' amendment that would reverse the interpretation that the district court had given to [a] statute, *even if that meaning was crystal clear*" before the amendment. *Paramount*, 138 F.3d at 710 (emphasis added). That concern was misplaced, because nothing in the *Loving* line suggests that Congress could in that way alter the meaning of a "crystal clear" statute. Nor is that concern presented here: by the Seventh Circuit's own characterization, the prior rules governing QMB reimbursement were not "crystal clear" but a "hopeless muddle." *Id.* at 711.

erning the States' cost-sharing obligations to providers under the Medicaid Act. That contention, however, necessarily depends on petitioners' characterization of Section 4714(a) as a change in the law rather than a clarification. Because, as we have explained, Section 4714(a) did clarify prior law, petitioners' constitutional arguments are not properly presented. For the same reason, the court of appeals had no occasion to address petitioners' constitutional arguments.

Even if petitioners' constitutional challenges were properly presented, they would lack merit. Petitioners first argue that the application of Section 4714 to their cases would violate the separation of powers principle set forth in *United States* v. *Klein*, 80 U.S. (13 Wall.) 128 (1872), by directing the outcomes of their cases. See 97-1947 Pet. 17-24; 97-1949 Pet. 21-25. This Court has made clear, however, that "[w]hatever the precise scope of *Klein*, * * * its prohibition does not take hold when Congress 'amend[s] applicable law.'" *Plaut* v. *Spendthrift Farm, Inc.*, 514 U.S. 211, 218 (1995) (quoting *Robertson* v. *Seattle Audubon Soc'y*, 503 U.S. 429, 441 (1992)). Without question, Section 4714(a) amended the law applicable to States' cost-sharing obligations to providers of medical services, and did not simply direct the outcomes of these particular cases. That point is underscored by the fact that Section 4714's amendment to Section 1396a(n) applies prospectively as well as to pending cases. Section 4714 therefore "*did* amend applicable law," *Seattle Audubon Soc'y*, 503 U.S. at 441, and *Klein* has no relevance to this case.

Petitioners' takings and due process challenges to Section 4714 under the Fifth Amendment are also without merit. As explained above, under Medicaid, the States, with the financial assistance of the federal government's matching funds, provide medical assis-

tance to the needy. The Secretary read the pre-1997 Medicaid Act to permit States to limit their cost-sharing payments to the difference between the State's Medicaid rate and the amount that Medicare would pay for a given service. California had chosen to exercise that option in its state plan. Even if Section 4714 changed the law, the change simply ratified the payment rules already set forth in California law; it did not change the amount that the *federal government* would pay providers. Because Section 4714 did not affect any contractual obligation of the federal government to petitioners, the cases on which they principally rely concerning contractual obligations of the federal government to private parties, *United States* v. *Winstar Corp.*, 518 U.S. 839 (1996), *Perry* v. *United States*, 294 U.S. 330 (1935), and *Lynch* v. *United States*, 292 U.S. 571 (1934), are inapposite.[9]

Thus, the only question is whether Section 4714 effected an unconstitutional taking or violated due process if (by hypothesis) it reduced the amount of cost-sharing that the States legally owed providers for services already rendered. As this Court recently reaffirmed, "a party challenging governmental action as an unconstitutional taking bears a substantial burden." *Eastern Enterprises* v. *Apfel*, 118 S. Ct. 2131, 2146

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[9] Petitioners' assertion that Congress made Section 4714 retroactive to save matching funds is both irrelevant and unsupported. Matching funds are owed to States, not to providers (see 42 U.S.C. 1396b (1994 & Supp. II 1996)); they do not affect the amount of compensation that providers receive for their services from the States. Moreover, Section 4714(a) is permissive. If all the States choose to pay cost-sharing in full, the federal government would still match those payments. Thus, any savings of matching funds would be, at most, "merely incidental" to Congress's regulatory objectives. See *Winstar*, 518 U.S. at 898.

(1998) (plurality opinion); see *id.* at 2156-2157 (Kennedy, J., concurring in the judgment and dissenting in part). Although a plurality of the Court in *Eastern Enterprises* held that the statute under review there effected an unconstitutional taking without just compensation, five members of the Court explicitly disagreed with that conclusion. In any event, the plurality did not disavow any of the Court's earlier takings cases reaffirming that Congress has "considerable leeway" (*id.* at 2149) in enacting social and economic legislation, even if that legislation has a retroactive effect. See *id.* at 2147-2149 (discussing *Connolly* v. *Pension Benefit Guar. Corp.*, 475 U.S. 211 (1986), and *Concrete Pipe & Prods. of Cal.* v. *Construction Laborers Pension Trust for Southern Cal.*, 508 U.S. 602 (1993)).

Application of that settled jurisprudence leads to the conclusion that Section 4714 is constitutional. In determining whether governmental regulation amounts to a taking, this Court considers the economic impact of the regulation, its interference with investment-backed expectations, and the character of the governmental action. See, *e.g.*, *Eastern Enterprises*, 118 S. Ct. at 2146 (plurality opinion); *Connolly*, 475 U.S. at 224-225. All three factors point to a conclusion that Section 4714(a) did not effect a taking. As for the economic impact of the legislation, whereas one plaintiff in *Connolly* had been assessed nearly 25% of that firm's net worth, see 475 U.S. at 222, petitioners have made no effort to show that Section 4714 would have a comparable economic impact on them. On the issue of investment-backed expectations, the law challenged in *Connolly* expanded the employers' obligation to pay benefits, even though those employers had contracts expressly limiting their obligations to pay benefits. See *id.* at 218. In contrast, the California Medicaid plan put petitioners on notice

that payment would be limited to the amount by which California's Medicaid rate exceeded what Medicare pays. See *California Med. Ass'n* v. *Lackner*, 172 Cal. Rptr. 815, 819 (Ct. App. 1981) (California Medicaid rules constitute a promise to pay providers "*at the rates set forth therein*") (emphasis added). Thus, at the time petitioners provided medical services, they had only their hope that their contested reading of the Medicaid Act would ultimately prevail and supersede their contracts with the State. Finally, as for the character of the government regulation at stake, Section 4714, like the statute upheld in *Connolly*, does not permit the government to "physically invade or permanently appropriate any of the [petitioners'] assets for its own use," *Connolly*, 475 U.S. at 225, nor does it have a severely retroactive effect out of proportion to petitioners' own experience, cf. *Eastern Enterprises*, 118 S. Ct. at 2149-2150 (plurality opinion). Petitioners' takings claim is therefore without basis.

Petitioners' due process challenge is similarly without merit. That argument ignores Congress's broad power to enact legislation "adjusting the benefits and burdens of economic life" and to make such legislation retroactive. *Usery* v. *Turner Elkhorn Mining Co.*, 428 U.S. 1, 15 (1976). Such legislation comes to a court "with a presumption of constitutionality, and * * * the burden is on one complaining of a due process violation to establish that the legislature has acted in an arbitrary and irrational way." *Ibid.* Retroactive economic legislation passes due process scrutiny as long as "the retroactive application of the legislation is itself justified by a rational legislative purpose." *Pension Benefit Guar. Corp.* v. *R.A. Gray & Co.*, 467 U.S. 717, 730 (1984).

Congress plainly had rational bases for making Section 4714 retroactive. First, Section 4714 conformed federal law to the state-law contract between providers and those States (like California) that had limited their cost-sharing payments to the difference between the State's Medicaid rate and the amount that Medicare paid. Second, Section 4714 conformed the law to the States' expectations, which were formed by the Secretary's longstanding construction of the Medicaid Act and by the Secretary's approval of state plans adhering to that construction. Finally, it was rational for Congress simply to "correct the unexpected results" of the decisions that rejected the Secretary's construction of Section 1396a(n). *General Motors Corp.* v. *Romein*, 503 U.S. 181, 191 (1992). Petitioners' due process challenge thus lacks merit.[10]

CONCLUSION

The petitions for a writ of certiorari should be denied.

Respectfully submitted.

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[10] Petitioner Gilmore asserts that retroactive application of Section 4714 violates the Contract Clause. See 97-1949 Pet. 25-28. It is well established, however, that Congress is not subject to the requirements of the Contract Clause. See, *e.g.*, *R.A. Gray*, 467 U.S. at 732-733.